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**Managing the self and other relationships: a father's role
when his partner and baby are hospitalised in a perinatal
mental health unit.**

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Doctorate in Clinical Psychology



The University of Edinburgh

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ABSTRACT

Objective

To examine the father's role when his partner and child are admitted to a perinatal mental health unit.

Background

Establishing attachment in the first months of life is crucial for infant mental health. Parental mental health and separation can interrupt the formation of attachment. Maternal postnatal mental health is known to affect the father's well-being and mental health. A systematic review conducted found paternal depression in the first year after birth affects child behavioural and emotional difficulties. One previous study has gathered limited evidence of fathers experiences of a perinatal mental health unit.

Method

Eight interviews were conducted with fathers whose partner was a current or former inpatient in a perinatal psychiatric unit in Scotland. Grounded Theory was utilised in the collection and analysis of data. No participants reported symptoms of Depression, Anxiety, or Stress at time of interview. Transcripts were coded by the researcher and supervisors and categories were compared. Additionally, results were validated by a participant before completing analysis.

Results

Maternal postnatal mental illness and hospitalisation was challenging. Long admissions with infrequent visits were most difficult. The overarching category 'managing the self and other relationships' captured the father's experience and how he tried to understand and manage, whilst making and maintaining family bonds. Five subcategories were Bonding with Baby, Keeping the Family Together, Feeling Contained, Feeling Overwhelmed, and Experiencing Uncertainty. Fathers had concerns about bonding and regarded the mother-baby bond as vital. Relationships were strained. Fathers experienced anxiety regarding illness and felt relief on admission. Fathers experienced demands such as work and travel. They tried to retain normality, take each day as it comes, and use family support to cope. Fathers were uncertain about illness and treatment and desired improved communication with professionals.

Conclusion

Severe maternal postnatal mental illness and inpatient admission affects fathers. Fathers have multiple demands which impact on participation in the unit. Father-infant bonding was affected by father availability. Recognition of the father's experience and increasing father's knowledge of illness and skills in caregiving is likely to improve the father's experience and benefit the family.

1. Paternal Depression in the Year Postpartum and the Effect on the Child: A Systematic Review.

Written for Child: Care, Health and Development, guidelines appendix 1a,
4587 words.

1.1 Abstract

Objective

To systematically review the research on paternal depression in the first year and the effect on the child.

Background

Maternal postnatal depression is implicated in child emotional, behavioural and cognitive difficulties. Paternal depression when their child is 3 years old or older is also associated with child emotional and behavioural difficulties.

Method

Embase, PsycInfo, Medline, ASSIA, ERIC, IBSS, CSA Social Services Abstract, and the Dissertation and Thesis databases were systematically searched between 1974 and November 2011. Search terms were father(s) OR paternal, AND depression OR depressed OR depressive, combined with each of the following: Infant(s) OR child OR children; development OR developmentally; parenting; and postnatal OR postpartum OR perinatal. Articles were critically analysed using quality criteria for the critical appraisal of observational studies (Petticrew & Roberts, 2006) which

analyses study design, method of sampling, description of sample, potential for bias, and methods of data collection. Fifteen studies were retained for review.

Results

Evidence supports an association between paternal depression in the first year and emotional regulation and behavioural difficulties in the child. There is some evidence a longer exposure to depression results in more difficulties, and that boys are more at risk. There was some support for an association with reduced language and cognitive abilities. The studies used a wide range of depression and child outcome measures, and relied heavily on self-report measures. The quality of the studies varied greatly. The evidence base was strengthened by several high quality longitudinal studies.

Conclusion

Paternal postnatal depression affects child behavioural and emotional difficulties. Further research into the mechanism by which paternal postnatal depression affects the child is required. Clinical implications are the treatment of paternal depression may have a positive effect on the child's psychological development.

Keywords: father; paternal; depression; postnatal; child; infant.

1.2 Introduction

Research in the field of parental mental health and child development has traditionally focussed on the mother. Maternal postnatal depression affects approximately 10-15% of women (Robertson *et al.* 2004) and is implicated in a range of adverse cognitive, behavioural and emotional difficulties in children (Murray & Cooper, 1997). Research on paternal mental health and the effect on the child has increased in recent years and will be considered in this review.

It is not only the mothers who may suffer with depression. Maternal depression has been found to correlate with (Paulson & Bazemore, 2010; Wee *et al.* 2011), and predict (Goodman, 2004) paternal depression in the first year after the child's birth. There is also a possible cumulative effect where an increase in one partner's depression could lead to an increase in the other partner's depression (Wee *et al.*, 2011). Prevalence rates of paternal depression in the year following birth vary between 1.2% and 29.2% (Bradley & Slade, 2010). Depressive symptoms are most prevalent in the 3 to 6 months postpartum period (25.6%, Paulson & Bazemore, 2010) and in men whose partner also had postnatal depression (24-50%, Goodman, 2004).

Authors are tentatively using the term paternal 'postnatal depression' referring to depression measured at the 8th week after birth (Ramchandani, O'Connor *et al.* 2008; Ramchandani, Stein *et al.* 2008). Both studies used a score of 12 or more on the Edinburgh Postnatal Depression Scale (EPDS; Cox *et al.* 1987) to indicate

depression. Goodman (2004) uses the term 'postpartum depression in men' (p.26) referring to depression measured up to 12 months after birth. However, Carro *et al.* (1993) refer to the postpartum period being up to 12 weeks after delivery. This review will refer to paternal depression in the year postpartum.

It is only recently the role of the father and his effect on his child's development has been studied in depth. The majority of research on paternal depression and the effect on the child focusses on older children (3 years and older). Kane and Garber (2004) in their meta-analysis demonstrated paternal depression was significantly related to child internalizing and externalizing problems and father-child conflict. In their later study, Kane and Garber (2009) found father's depressive symptoms (when the child was an average of 11.8 years) were associated with child internalizing and externalizing difficulties independent of the effect of maternal depression. Another study which used a large sample, valid and reliable measures, and with results generalizable to the general population found paternal depression was associated with more emotional and behavioural problems in their child independently of any effects of maternal depression (Weitzman *et al.* 2011). There is also evidence suggesting paternal depression can affect cognitive development. For example, Wanless *et al.* (2008) found conflicting evidence in the literature but overall concluded that paternal depression limits the involvement a father has with his child, which then influences cognitive development.

The early years of a child life, particularly the first year, is a time of enormous cognitive development (Gale *et al.* 2004) and it is a time when the child is

particularly sensitive to parent-level influences (Paulson *et al.* 2006). Due to the mounting evidence of the effects of paternal depression on children, and the high prevalence rates of paternal postnatal depression, it is an important time to review this subject. This review will focus on father's depression in the first year after his child's birth and the effect on the child

A search of three databases (Embase, PsycINFO and Ovid MEDLINE) revealed a similar review by Goodman (2004). This review examined literature on paternal postpartum depression and its interaction with the mothers depression and family health, up to 2002. The review concluded there was limited research on postpartum depression in fathers and further longitudinal research was required. Since then there has been several large longitudinal studies. For example Ramchandani, O'Connor, *et al.* (2008) found children whose fathers were depressed over the pre- and postnatal period were at greater risk of emotional and behaviour problems at 3.5 years, and more likely to have a psychiatric diagnosis at 7 years. Additionally, child temperament at 24 months was more difficult when the father had been depressed at 6 months (Hanington *et al.* 2010). During the search no systematic reviews focussing on father's depression in the postnatal period and the effect on the child were found.

1.3. Method

1.3.1. Identification of studies

Three OVID databases were searched, these were Embase, PsycINFO, and Medline. The search was limited to English Language studies published between 1974 and November 2011, and to studies of children aged under 5 years. Duplicate studies were removed automatically. This identified 5083 articles.

Four CSA databases were searched, these were ASSIA, ERIC, IBSS and CSA Social Services Abstracts. The entire databases were searched up to November 2011. This identified a further 2832 articles.

The Dissertations and Theses database was searched, limited to articles from 1974 to November 2011. This identified a further 1056 articles.

Authors of unpublished articles identified in the search, and a leading academic, were contacted to identify and retrieve additional articles. The reference lists of the final selected papers were searched to identify relevant articles which could have been missed.

1.3.2. Search terms

The search terms used were father(s) OR paternal, AND depression OR depressed OR depressive, combined with each of the following: Infant(s) OR child OR

children; development OR developmentally; parenting; and postnatal OR postpartum OR perinatal, see Table 1.

Table 1. Search terms.

Father (s) OR paternal AND Depression OR depressed OR depressive <i>Combined with each of the following:</i> Infant (s) OR child OR children. Development OR developmentally. Parenting. Postnatal OR postpartum OR perinatal
--

1.3.3. Inclusion criteria

Studies were retained if they met the following inclusion criteria:

- English language studies.
- A valid and reliable measure of paternal depression within the first year after the child's birth.
- A measure of child outcomes.

Exclusion Criteria

Studies were excluded if they met one or more of the following criteria:

- Children were physically ill or disabled.
- Co-morbid substance misuse.
- Non-resident fathers.
- Non-western cultures.
- Duplicate studies.
- Irrelevant to the review question.

1.3.4. Quality Assessment

Articles which were accepted after being judged against the inclusion and exclusion criteria were then critically analysed. They were analysed using quality criteria for the critical appraisal of observational studies (p.136. Petticrew & Roberts, 2006) which was adapted from the Centre for Reviews and Dissemination handbook. This included analysing study design, method of sampling, description of sample, potential for bias, and methods of data collection. The quality criteria and analysis of studies are displayed in Table 2.

Table 2. Quality criteria and assessment.

Quality Criteria	Method of sampling	Relevance of population sampled	Description of participants	Adequate comparison or control group?	Independent and dependent variables adequately measured?	Measures most relevant for answering the research question?	Has participant drop-out introduced bias?	Is the study long enough to allow changes in the outcome of interest to be identified?	Is the study large enough to allow changes in the outcome of interest to be identified?	Has the method of measuring the outcome introduced bias?	Generalisability: are the results representative of the population?
Study											
Carro, Grant, Gotlib & Compas (1993).	Adequately addressed	Adequately addressed	Adequately addressed	Not applicable	Well covered	Well covered	No	Well covered	Adequately addressed	No	Adequately addressed
Dave, Nazareth, Sherr & Senior (2005).	Adequately addressed	Adequately addressed	Well covered	Not applicable	Well covered	Well covered	Yes	Not applicable	Poorly addressed	No	Poorly addressed
Field, Hossain & Malphurs (1999).	Well covered	Adequately addressed	Well covered	Well covered	Well covered	Adequately addressed	Not Applicable	Not applicable	Adequately addressed	No	Poorly addressed
Hanington, Ramchandani, & Stein (2010).	Well covered	Well covered	Well covered	Not applicable	Well covered	Well covered	No	Well covered	Well covered	Slight risk	Well covered
Hart, Field, Stern & Jones (1997).	Adequately addressed	Adequately addressed	Well covered	Well covered	Well covered	Adequately addressed	Not Applicable	Not applicable	Adequately addressed	No	Poorly addressed
Kaplan, Sliter & Burgess (2007).	Adequately addressed	Adequately addressed	Well covered	Well covered	Well covered	Well covered	No	Not applicable	Adequately addressed	No	Poorly addressed
Malmberg & Flouri (2011).	Well covered	Well covered	Adequately addressed	Adequately addressed	Adequately addressed	Adequately addressed	No	Well covered	Well covered	No	Well covered
Mezulis, Hyde & Clark (2004).	Adequately addressed	Adequately addressed	Poorly addressed	Not applicable	Adequately addressed	Adequately addressed	No	Well covered	Well covered	No	Adequately addressed

Table 2. Quality criteria and assessment continued.

Quality Criteria	Method of sampling	Relevance of population sampled	Description of participants	Adequate comparison or control group?	Independent and dependent variables adequately measured?	Measures most relevant for answering the research question?	Has participant drop-out introduced bias?	Is the study long enough to allow changes in the outcome of interest to be identified?	Is the study large enough to allow changes in the outcome of interest to be identified?	Has the method of measuring the outcome introduced bias?	Generalisability: are the results representative of the population?
Study											
Paulson, Keefe, & Leiferman (2009).	Well covered	Well covered	Well covered	Not applicable	Well covered	Adequately addressed	No	Well covered	Well covered	Slight risk	Well covered
Pemberton, Neiderhiser, Leve, Natsuaki, Shaw, Reiss & Ge (2010).	Well covered	Adequately addressed	Adequately addressed	Not applicable	Well covered	Well covered	No	Adequately addressed	Well covered	No	Adequately addressed
Perren, Wyl, Burgin, Simoni & Klitzing (2005).	Adequately addressed	Adequately addressed	Well covered	Not applicable	Well covered	Well covered	Yes	Well covered	Poorly addressed	No	Poorly addressed
Pesonen, Raikonen, Strandberg, Keltikangas-jarvinen & Jarvenpaa (2004).	Adequately addressed	Adequately addressed	Poorly addressed	Not applicable	Well covered	Well covered	Not Applicable	Not applicable	Well covered	No	Adequately addressed
Ramchandani, O'Connor, Evans, Heron, Murray, & Stein (2008).	Well covered	Well covered	Well covered	Not applicable	Well covered	Well covered	No	Well covered	Well covered	No	Well covered
Ramchandani, Psychogiou, Vlachos, Iles, Sethna, Netsi & Lodder (2011).	Well covered	Well covered	Well covered	Well covered	Well covered	Well covered	Not Applicable	Not applicable	Adequately addressed	No	Adequately addressed
Ramchandani, Stein, O'Connor, Heron, Murray & Evans (2008).	Well covered	Well covered	Adequately addressed	Not applicable	Well covered	Well covered	No	Well covered	Well covered	No	Well covered

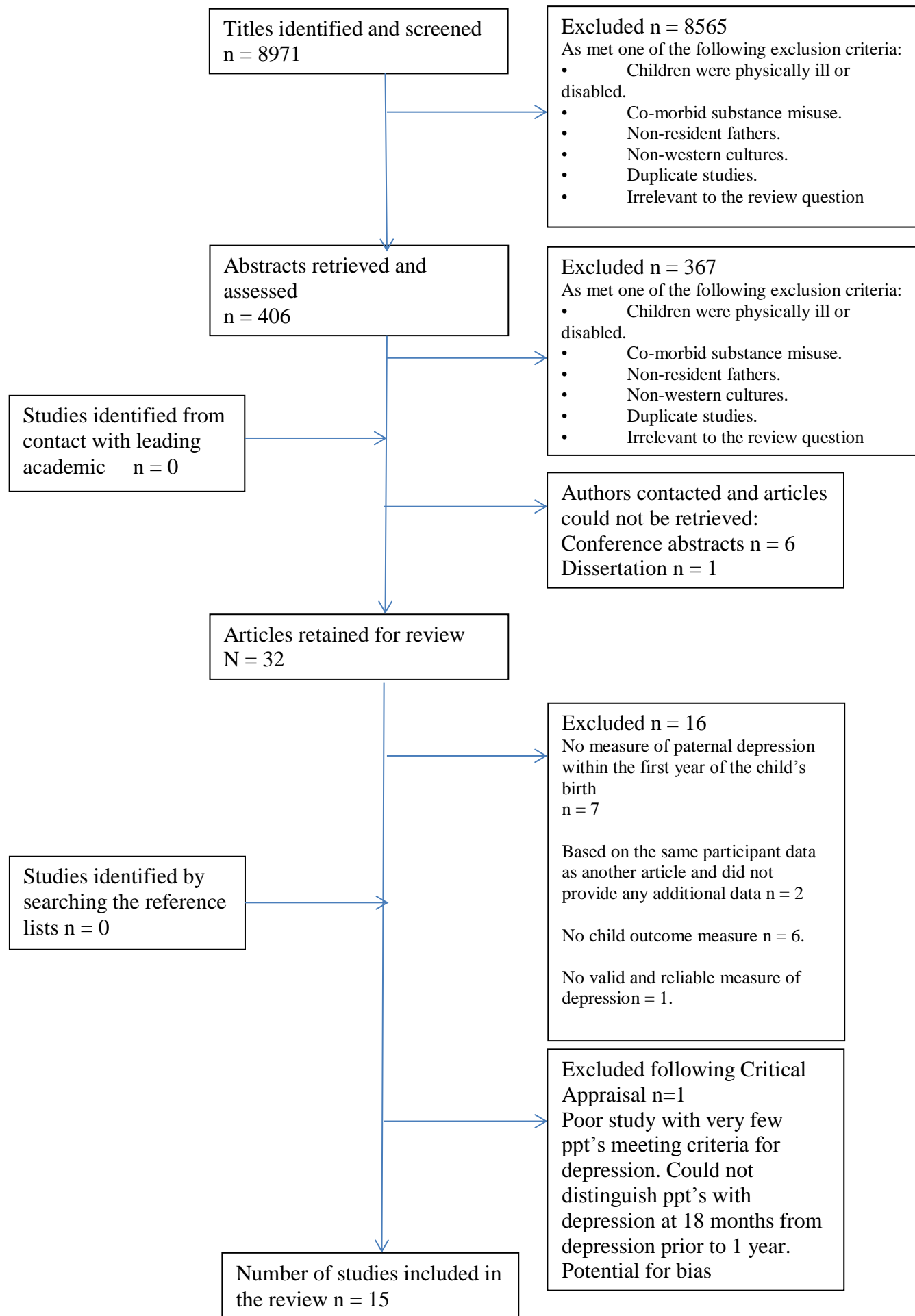


Figure 1. Flowchart for article selection.

1.3.5. Article selection

In total 8971 articles were identified. 8932 articles were removed as they met exclusion criteria. The authors were contacted for seven unpublished articles, unfortunately these articles were not available for the review but several may be published in 2012. Thirty two full papers were read in their entirety. Seven papers were excluded because they did not measure paternal depression within the first year of the child's birth. Two papers were excluded because they were based on the same participant data as another article and did not provide additional data. Six were excluded because they did not have a child outcome measure. One was excluded because it did not have a valid and reliable measure of depression. Sixteen articles remained which were critically analysed. One article was excluded as very few participants met the criteria for depression, and there was no separate analysis of participants with depression at 18 months or depression prior to 1 year. Generally it was a poor study with the potential for bias as many chose not to complete the depression measure. Therefore 15 articles were retained for review. The selection process is summarised in Figure 1.

1.4. Results

1.4.1. Measures

A range of depression measures were used. Two studies used multiple assessments. Six of the fifteen studies used the Edinburgh Postnatal Depression Scale (EPDS; Cox *et al.* 1987). Four studies used the Beck Depression Inventory (BDI; Beck & Steer, 1993, 1996). Four studies used the Centre for Epidemiological Studies Depression Inventory (CES-D; Radloff, 1977). Each of the following were used in one study: the Hospital Anxiety and Depression Scale (HADS; Zigmond & Snaith, 1983), the Brief Patient Health Questionnaire (Spitzer *et al.* 1999), the 9 item version of the Malaise Inventory (Rutter *et al.* 1970), and a structural clinical interview for DSM-IV (Gorman *et al.* 2004).

Thirteen different child outcome measures were used. Three of the fifteen studies used the Infant characteristics questionnaire (Bates *et al.* 1979). Each of the following measures were included in two studies; the Child behaviour Checklist (CBCL; Achenbach, 1992), the Strengths and Difficulties Questionnaire (Goodman, 1997), the Infant Behaviour Questionnaire (Rothbart, 1981), and the Development and Well-being Assessment (Goodman *et al.* 2000). Each of the remaining measures were used in one study; an Interaction Rating Scale (Field, 1980), the Carey Temperament Scales (Carey & McDevitt, 1987), the Vulnerable Child Scale (Perrin *et al.* 1989), the Infant Stereotyping Scale (Martinez *et al.* 1995), the Health and Behaviour Questionnaire (Essex *et al.* 2002), the MacArthur Communicative Development Inventory (Fenson *et al.* 1994), the Rutter Revised Preschool Scales

(Elander & Rutter, 1996), and finally the duration infants looked at a screen was assessed (interobserver reliability of .94).

Details of the included studies, their sample size, design, measures used, and the main findings are summarized in Table 3. Nine of the included studies were longitudinal and the remaining six were cross-sectional.

1.4.2. Prevalence of Paternal Depression in the Year Postpartum

The prevalence of paternal depression in fathers during the first year after their child's birth and depression measure used are as follows; 3% on the EPDS (Hanington *et al.* 2010); 3.4% on the EPDS (Ramchandani, O'Connor *et al.* 2008); 4-6% at each time point on the EPDS (Perren *et al.* 2005); 8.3% on the HADS, and 8.3% on the EPDS (Dave *et al.* 2005); 13% on the BDI (Carro *et al.* 1993); between 10.2% and 15.6% on the CES-D (Mezulis *et al.* 2004); and 29.3% with symptoms in the mild to severe range (19.7% mildly depressed, 6% moderately depressed and 3.7% severely depressed) on the CES-D (Paulson *et al.* 2009).

Table 3. Summary of Articles Reviewed (1 of 4)

Authors and year	Sample	Design	Measure of fathers depression	Child Assessments	Main Findings
Carro, Grant, Gotlib & Compas (1993).	70 couples and their children (13% of male participants depressed)	Longitudinal study. Questionnaires completed an average of 4.5 weeks after delivery. Subsequent data was collected when the child was between 2 and 3 years of age.	Beck Depression Inventory	Childrens internalizing and externalizing behaviour was measured by the Child Behaviour Checklist (CBCL; Achenbach, Edelbrock, & Howell 1987).	Father's depression at postpartum is a risk factor for child behaviour problems at 2-3 years through the depressed fathers contribution to the mother's depression and distress.
Dave, Nazareth, Sherr & Senior (2005).	Out of original 48 fathers of newborns (8% depressed). In this study only 17 fathers returned both depression measures and infant follow-up assessments.	Cross sectional. Six months after birth fathers completed Questionnaires	Hospital Anxiety and Depression Scale, and Edinburgh Postnatal Depression Scale. Brief Patient Health Questionnaire (Brief PHQ; Spitzer, Kroenke, & Williams, 1999), that provides a DSM IV diagnosis of depression and anxiety.	Infant fussiness measured by the Infant Characteristics Questionnaire (6-month version).	Higher paternal depressed mood is associated with more difficult infant temperament.
Field, Hossain & Malphurs (1999).	80 families (in 4 groups of 20)	Cross sectional. Questionnaires administered and videos of parent-child interactions were rated.	Beck Depression Inventory	The first subscale of the Interaction Rating Scale (IRS) measures the infant's state.	The infants interactions were unaffected by their fathers depression.
Hanington, Ramchandani, & Stein (2010).	6170 fathers completed study. 3% of fathers were depressed at 6-8 months.	longitudinal study.	Mothers and fathers completed the Edinburgh Postnatal Depression Scale (EPDS) at 6 to 8 months and 21 months after the birth of their baby.	Child temperament was measured at 6months and 24 months of age using the Carey Temperament Scales (CTSs).	Paternal depression at time 1 leads to more difficult temperament at time 2 only for male children.

Table 3. Summary of Articles Reviewed Continued (2 of 4).

Authors and year	Sample	Design	Measure of fathers depression	Child Assessments	Main Findings
Hart, Field, Stern & Jones (1997).	25 fathers (13 depressed) of 4-month old infants.	Cross sectional. Rated videotaped infants, and their own infants. Data collected at 1 time point.	Center for Epidemiological Studies depression Inventory (CES-D).	Vulnerable Child Scale (alpha 0.79) relating to parents perceptions of their infants physical robustness and the extent to which parents feel confident their child is thriving. Fathers rated their child on the Infant Stereotyping Scale (ISS).	Compared to non-depressed fathers depressed fathers rated their own infants lower on social behavior, potency, and cognitive competence as well as rating them as more vulnerable. Furthermore, depressed fathers rated other infants lower on potency, sociability, and cognitive competence.
Kaplan, Sliter & Burgess (2007).	39 fathers and their 5- to 12.5-month-old infants. For the infant learning category only 32 infants completed, 11 of whom had fathers in the elevated depression category.	Cross sectional. Participants completed all measures at same time point.	Beck Depression Inventory-II	Duration of Infant looking at screen observed, interobserver reliability = .94	Elevated symptoms of depression in fathers is linked to poorer infant learning in response to paternal speech, paternal depression adversely affects infant learning in a conditioned-attention paradigm
Mahnberg & Flouri (2011).	11286 families	Longitudinal. Parents depression was measured in sweep one when child was 9 months, father-child relationships were measured in sweep 2 when child 3 years	Depressed mood measured using a nine-item version of the Malaise Inventory.	Strengths and Difficulties Questionnaire completed by the mother.	They found that, particularly in fathers, parental depressed mood predicted child outcomes by its impact on the quality of the parent-child relationship.
Mezulis, Hyde & Clark (2004).	350 families	Longitudinal	Center for Epidemiological Studies depression Inventory (CES-D). It was administered at 1 month, 4 months, 12 months, and when the child was in kindergarten.	Health and Behaviour Questionnaire (HBQ) administered to teacher. Reliability exceeds .70 in this sample.	Paternal depression in a child's infancy exacerbated the negative effects of maternal depression on child internalizing behavior problems in kindergarten only if the father spent high amounts of time with the infant, the effect was not observed for externalizing behaviors.

Table 3. Summary of Articles Reviewed Continued (3 of 4).

Authors and year	Sample	Design	Measure of fathers depression	Child Assessments	Main Findings
Paulson, Keefe, & Leiferman (2009).	4109 families from the Early Childhood Longitudinal Study 9month and 24 month waves.	Longitudinal	Depression measured at 9 months with the Center for Epidemiological Studies Depression (CED-D) scale.	Child expressive vocabulary measured using a 50 item subset of the MacArthur Communicative Development Inventory (widely used).	Depression has a more marked impact on the father's (rather than the mother's) reading to their child and, subsequently, the child's language development.
Penberton, Neiderhiser, Leve, Natsuaki, Shaw, Reiss & Ge (2010).	351 adoptive parent couples (and 95 birth fathers).	Longitudinal. Birth parents depression measured at 3 - 6 months and 18 months. Adoptive parent depression measured at 9, 18, & 27 months.	Birth parent and adoptive parents depression measured with Beck Depression inventory.	At 27 months the adoptive mother and adoptive father completed the Child Behaviour Checklist- In this study only the externalizing problems were analysed. At 9 months the Infant Characteristics Questionnaire was completed.	Adoptive father depressive symptoms when the infant was 9 months old is associated with toddler externalizing problems.
Perren, Wyl, Burgin, Simoni & Klitzing (2005).	58 fathers.	Longitudinal	Edinburgh Postnatal Depression Scale, completed at second trimester of pregnancy, 1, 3, 12 and 18 months after birth.	Child difficulty-fussiness was assessed using the Infant Characteristics Questionnaire at 3, 12, and 18 months after birth.	Child difficulty seemed to affect fathers stress more than mothers but no association was found between depression and child difficulty.
Pesonen, Raikkonen, Strandberg, Keltikangas-jarvinen & Jarvenpaa (2004).	173 fathers (319 mothers) (from 328 families).	Cross sectional. Questionnaires completed 6 months after the child's birth.	Center for Epidemiological Studies Depression Scale - 10.	Infant Behaviour Questionnaire.	Paternal (and maternal) depressive symptoms were significantly associated with perceptions of the infant having a temperament that is more fearful, distressed to limitations, and more negatively reactive.

Table 3. Summary of Articles Reviewed Continued (4 of 4).

Authors and year	Sample	Design	Measure of fathers depression	Child Assessments	Main Findings
Ramchandani, O'Connor, Evans, Heron, Murray, & Stein (2008).	Avon Longitudinal Study of Parents and Children. 7601 fathers completed depression measures. 6449 fathers remained in study at 3.5 years. 5483 fathers remained in the study at 7 years.	Longitudinal study. Fathers depression assessed in week 18 of partners pregnancy and 8 weeks after birth. Child's emotional and behaviour problems assessed at 3.5 years. Child's well-being assessed at 7 years.	Edinburgh Postnatal depression scale.	The Rutter revised Preschool Scales, and the Development and Well-Being Assessment (DAWBA) questionnaire.	Children whose fathers are more chronically depressed appear to be at a greater risk of emotional and behaviour problems. Boys whose fathers had depression only in the postnatal period were at higher risk of conduct problems.
Ramchandani, Psychoygiou, Vlachos, Iles, Sethna, Neisi & Lodder (2011).	54 fathers with a diagnosed depressive disorder (19 currently depressed), 99 fathers without a diagnosed depressive disorder.	Cross sectional, controlled study.	Structural Clinical Interview for DSM-IV when infant 3 months. The Edinburgh Postnatal Depression Scale was used at 7 weeks as a screening measure.	Infant Behavior Questionnaire-Revised.	When fathers with current depression were compared to fathers with no depression, those with depression reported more distress in their infants. When the mother completed the questionnaire the infants of currently depressed fathers had a tendency to score lower on the laughter and smiling scale. Fathers in the depressed groups had infants with higher levels of distress reported, and this was particularly true for fathers with current depression.
Ramchandani, Stein, O'Connor, Heron, Murray & Evans (2008).	Avon Longitudinal Study of Parents and Children. Data available for 6075 children whose father completed depression measures at 8 weeks.	Fathers depression assessed at 18 weeks of partners pregnancy, 8 weeks, 8 months and 21 months after birth. Child assessed at 6 years and 7 years.	Edinburgh Postnatal depression scale.	The Strengths and Difficulties Questionnaire used at 6 years. The Development and Well-Being Assessment used at 7 Years.	As this uses much of the same data as Ramchandani, O'Connor et al. (2008) only the results from the Strengths and Difficulties questionnaire will be examined. Postnatal depression in fathers was associated with increased scores on the prosocial (reverse scored), hyperactivity, conduct problems, peer problems, and total problems scales. When controlling for maternal depression and paternal educational level, difficulties in the peer problems, and prosocial problems domains remained. This difficulty with peers also remained when the study controlled for the effects of later depression in fathers (at 21 months).

1.4.3. Early Infant Emotional Regulation

Five studies investigated the relationship between paternal depression and infant temperament in infants aged between 3 and 6 months. Two studies examined infant fussiness in older infants. The behaviours that constitute infant temperament are the behaviours infants engage in to regulate their emotional arousal (Mangelsdorf *et al.* 1995). Of the seven studies only 2 showed no effect of paternal depression on infant temperament. Field *et al.*'s (1999) study found no difference between how infants behaved with depressed and non-depressed fathers. Perren *et al.* (2005) found no association between paternal depression and child difficulty (fussiness) at 3, 12, or 18 months.

Fathers who were depressed reported significantly more distress in their infants, with a higher level of depressive symptoms being associated with more distress (Ramchandani *et al.* 2011). Fathers with more depressive symptoms described their infants as more negatively tuned, more fearful, more distressed to limitations, and more negatively reactive (Pesonen *et al.* 2004). Depressed fathers rated their children as more vulnerable, and lower on 'social behaviour' (less cuddly and fussier) than non-depressed fathers did (Hart *et al.* 1997). Two studies found paternal depression was associated with infant fussiness (Dave *et al.* 2005; Pemberton *et al.* 2010). Interestingly, infant fussiness was not associated with the time the father had available for his child, or the amount of father-child activity (Dave *et al.* 2005). Two studies differed regarding the association between paternal depression and infants laughing and smiling less. One study showed infants of currently depressed fathers scored lower on the laughter and smiling scale, particularly for girls (Ramchandani *et al.* 2011). Whereas no association was found between paternal

depression and the father's perception of how much their child laughs and smiles in Pesonen *et al.*'s (2004) study.

The evidence also suggests a father's current depression may be affecting his interpretation of his infant's temperament. For example, paternal depressive symptoms were found to be a significant predictor of a father's perception of his infant's temperament (Pesonen *et al.* 2004). Current depression was found to have more of an effect on infant temperament than a previous episode of depression (Ramchandani *et al.* 2011). Moreover, fathers who are depressed were more likely to rate unfamiliar infants as lower on 'potency' (weaker and slower), 'sociability' (more sad and more shy), and lower on the overall summary score of the Infant Stereotyping scale than a non-depressed father would.

1.4.4. Emotion Regulation in children aged 2 to 5 years

Five of the studies investigated the association between paternal depressed mood in the first year and child emotion regulation when aged between 2 and 5 years. One study did not find an association between paternal depression and later child emotional difficulties (Malmberg & Flouri, 2011). Equally a second study found paternal depression on its own was not significantly associated with child internalizing problems. However, when the mother also had postnatal depression and the father interacted a lot with the child, paternal depression did negatively affect child internalizing behaviour (Mezulis *et al.* 2004).

The remaining three studies found children of fathers who had been depressed in the first postnatal year were more likely to show internalizing difficulties (Carro *et al.*

1993), emotional problems (Ramchandani, O'Connor *et al.* 2008), and more difficult temperament at 26 months of age (both in terms of child mood and the intensity of emotional response) (Hanington *et al.* 2010).

Sons showed increased rates of emotional problems when fathers were depressed in either the pre- or postnatal period or at both times (Ramchandani, O'Connor *et al.* 2008). Moreover, when the effects of the mother's postnatal depression, earlier child mood/intensity, and later paternal depression were controlled for, early paternal depression was found to only have a significant independent effect on boy's temperament (Hanington *et al.* 2010).

The effect of paternal depression on the child's internalizing behaviour is complexly influenced by maternal depression. In contrast to Mezulis *et al.* (2004), Carro *et al.* (1993) found when the mother also had high levels of depression fathers depression did not predict child internalizing problems, however it did when maternal depression was low.

1.4.5. Behaviour Regulation

Six studies investigated the association between paternal depression in the first year after birth and child externalising difficulties when the child was aged between 2 and 6 years. Five of the studies supported an association between paternal depression in the first year and behavioural difficulties. One study by Mezulis *et al.* (2004) which primarily was studying the mothers, found paternal depression was not significantly associated with child externalising problems at age 5 years.

Father's symptoms of depression at one month predicted their child's externalizing behaviour problems at 2 to 3 years (Carro *et al.* 1993). Paternal depressed mood at 9

months predicted externalizing behaviour difficulties at age 27 months (Pemberton *et al.* 2010) and 3 years (Malmberg & Flouri, 2011). Likewise, paternal depression was associated with difficulties with hyperactivity, conduct problems, peer problems, and poor prosocial skills when the child was 6 years old (Ramchandani, Stein *et al.* 2008). Furthermore, paternal depression in the year postpartum was found to be associated with (Ramchandani, Stein *et al.* 2008) and predictive of (Carro *et al.* 1993; Malmberg & Flouri, 2011) total behavioural difficulties in the child in later years.

Children of fathers who were depressed in the prenatal or postnatal period, or at both times, had higher rates of behavioural problems at 3.5 years of age than children whose fathers had not had depression at these times. Additionally, when the depression persisted throughout the pre- and postnatal period the child was more likely to have more conduct, and hyperactivity difficulties. Sons were more affected than daughters (Ramchandani, O'Connor *et al.* 2008).

The effect of paternal depression on child behaviour difficulties was independent of the effect of maternal depression, paternal education level, marital status, and the presence of other children (Ramchandani, O'Connor *et al.* 2008). In contrast, Carro *et al.* (1993) found paternal depression at one month predicted maternal depression at 2 to 3 years, so they concluded that father's depressive symptoms at one month predicted child behaviour problems at 2 to 3 years through the effect the father has on the mother's mood. One study found paternal depression affected child externalizing difficulties by the effect depression had on the quality of the father-child relationship (Malmberg & Flouri, 2011). Furthermore, chronicity of depression

may be important; the children whose fathers were more chronically depressed were at greater risk of behaviour problems (Ramchandani, O'Connor *et al.* 2008).

1.4.6. Psychiatric diagnosis

Children whose fathers had been depressed in either the pre- or postnatal period, or at both times, were more likely to have a psychiatric diagnosis at 7 years of age (Ramchandani, O'Connor *et al.* 2008).

1.4.7. Language

Paulson *et al.* (2009) reported that a father's depression at 9 months is a negative predictor of his child's expressive vocabulary at 24 months. It was thought this reduced expressive vocabulary may be partially due to the father's depression at 9 months negatively predicting the amount he read to his child at 9 and 24 months. So the more depressed he was the less he read to his child.

1.4.8. Cognitive Competence

Finally, two studies mentioned cognitive competency. Depressed fathers rated their children lower on 'cognitive competency' (less smart and not paying attention) than non-depressed fathers did, however they were also more likely to rate unfamiliar infants as lower on 'cognitive competence' (Hart *et al.* 1997). However, in an experimental study higher paternal depression scores on the BDI were associated with the infants displaying significantly poorer learning in response to the father's

speech. This effect was independent of any qualities of the father's speech, or how much the father was involved in childcare (Kaplan *et al.* 2007).

1.5. Discussion

Fifteen studies were identified which investigated the impact of paternal depression in the first year after birth and the effect on the child. The evidence supports an association between paternal depression in the first year and infant emotional regulation difficulties, and later emotional and behavioural difficulties in the child.

There is some evidence that boys are more at risk than girls.

Although seven studies investigated the effect on early infant emotional regulation the quality of these studies was not as methodologically strong as studies on childhood emotional and behavioural regulation as assessed by the quality criteria.

For example two studies may have been affected by large drop-out rates and small samples (Dave *et al.* 2005; Perren *et al.* 2005). It was Perren *et al.* (2005) that found no association between depression and fussiness; the small sample size could mean the researchers had insufficient power to detect an effect so wrongly accepted the null hypothesis, a power calculation could be done to estimate the required sample size for future studies. Dave *et al.* (2005) compensated for the drop-out by using depression scores rather than comparing a depressed and non-depressed group. All seven of these studies were strong in the measures they used to assess variables.

Ramchandani *et al.* (2011) was the strongest study in terms of sampling, measures and generalizability of results. The seven studies varied greatly in terms of the child outcomes measured which makes validating the findings against another study difficult. When studies used the same outcome measures there was some disagreement, in each case the stronger study supported an association between paternal depression and difficult infant temperament. In conclusion, the evidence is

weighted towards an association between paternal depression and more difficult early infant temperament/emotion regulation. Considering the roots of emotional regulation begin in 'babyhood' (Gerhardt, 2004). The finding that paternal depression affects emotional regulation at this age are a concern to the child's psychological development.

Findings for the effect of paternal depression in the first year and emotion regulation in children aged 2 to 5 years are less consistent, although results are weighted towards an association between depression and emotion difficulties. The effect may be strongest for boys. The association appears complexly influenced by maternal depression and the amount of interaction the father has with his child. The quality of these studies was good and several included large samples with results generalizable to the UK population (Hanington *et al.* 2010; Malmberg & Flouri, 2011; Ramchandani, O'Connor *et al.* 2008).

Studies strongly supported the association between paternal depression in the first year and behavioural difficulties between 2 and 6 years. The weakest of the six studies as assessed by the quality criteria was the only one that did not support an association; Mezulis *et al.*'s (2004) study was weaker in terms of sampling methods, description of participants, assessment measures, and generalizability of findings. Again there was support that sons may be more affected. There was a discrepancy as to whether the effect was mediated by maternal mood; Ramchandani O'Conner *et al.* (2008) found the affect was independent of maternal depression and this study was stronger than Carro *et al.*'s (1993) study on the majority of the quality criteria. The

longer a child was exposed to paternal depression the greater risk of behavioural problems.

One longitudinal study which scored highly on the quality criteria in terms of sampling, assessment measures, minimisation of bias, and generalizability, found children were more likely to have a psychiatric diagnosis at 7 years of age if their father have been depressed in the pre- or postnatal period. Similarly, one large UK based longitudinal study with strong sampling and assessment methods found father's depression predicted his child having a reduced expressive vocabulary. The evidence for an association between paternal depression and a child's cognitive competence is based on much smaller studies with populations which are not generalizable to the UK population and more studies are required in these areas.

Across the 15 studies there was a wide range of measures used to assess depression. Questionnaires designed for general psychiatric use, such as the BDI, may not be entirely appropriate for use in the postnatal period as they ask about energy levels, sleep, and tiredness which are all normally affected by caring for a new baby. The EPDS is designed for postnatal use but it is also sensitive to anxiety (Bradley & Slade, 2010). Furthermore, the EPDS, CES-D, GHQ, BDI and HADS all assess current symptoms of depressive mood but are not diagnostic tools (Wee *et al.* 2011). Using a diagnosis of depression in studies could strengthen the research base however it is unlikely to occur in large population based studies due to time and cost constraints.

There was little consistency in the child outcome measures used. Furthermore, the studies rely heavily on self-report child measures completed by parents. Although there is a potential for bias there are studies which show paternal observations and parent rated measures were the most valid predictor of later child outcomes (Asendorpf, 1990; Schmitz *et al.* 2001). More consistency in child outcomes studied and using outside observers may clarify the literature on the effect on infant emotional regulation in particular.

In this review there is little consensus on how paternal depression impacts on the child. Some studies have found paternal depression is associated with child difficulties independent of maternal depression, others have found it is a complex interaction with the mother's depression and the quality of interactions with the child. Pesonen *et al.* (2004) found avoidant and anxious-insecure adult attachment influences infant temperament through the effect it has on the parents depression. From the studies reviewed the more robust studies support an independent effect of paternal depression but a firm conclusion cannot be made.

Strengths and weaknesses of the reviewed papers

Although the fifteen studies varied in their methodology the majority of the studies were of intermediate or high quality, as assessed on the quality criteria. All studies were particularly strong in the use of valid and reliable measures of paternal depression and child outcomes.

The majority of studies used good sampling methods with several using birth cohort sampling (e.g. Hanington *et al.* 2010; Ramchandani, O'Connor *et al.* 2008), however

some studies recruited the fathers through the mothers (e.g. Carro *et al.* 1993) which could potentially lead to bias for example only fathers within good relationships finding out about the study. The strongest studies as assessed by the quality criteria (Hanington *et al.* 2010; Malmberg & Flouri, 2011; Paulson *et al.* 2009; Ramchandani, O'Connor *et al.* 2008; and Ramchandani, Stein *et al.* 2008) were large cohort sample, longitudinal studies with results generalizable to the general population. Longitudinal studies are beneficial as they allow inferences to be made about the direction of effects e.g. early paternal depression is associated with later child difficulties. An equally high quality study was that of Ramchandani, Psychogiou *et al.* (2011) which in addition to strong sampling was very thorough in the assessment of depression and child measures; father's depression was assessed using a structural clinical diagnostic interview in addition to assessing severity of depressive symptoms on a scale which allows the impact of clinical levels of depression to be tested, and child measures were reported by both parents which reduces opportunity for reporter bias.

Individual studies had the added benefit of assessing additional factors which have the potential to moderate and mediate the association between paternal depression and child outcomes. Such as maternal depression (e.g. Malmberg & Flouri, 2011), relationship quality (Carro, *et al.* 1993), stress (Perren *et al.* 2005), parenting style and time with infant (Mezulis *et al.* 2004), and attachment style (Pesonen *et al.* 2004), these studies provide further insight into the mechanism by which paternal depression may affect children but a further study incorporating each of these factors and the associations between them would be helpful.

Overall the majority of studies were of strong quality yet there were some weaknesses. Two studies were of poor quality as assessed by the quality criteria (Dave *et al.* 2005; Perren *et al.* 2005), these studies both had the potential for biased results as many of the fathers with higher depressive symptoms dropped out of the study. Furthermore they both had small sample sizes which means there may not have been sufficient statistical power to accurately accept the null hypothesis, and both of these studies did accept a null hypothesis for example Perren *et al.* (2005) found no association between paternal depression and infant fussiness. Another area of potential bias was two of the experimental studies were conducted in laboratory settings (Field *et al.* 1999; Kaplan *et al.* 2007) and authors commented that the unnatural setting may have affected the father's interactions with their infants. Future studies of this kind may benefit from being conducted within the home environment.

Relevant theories

Attachment theory and social learning theory literature could explain the transfer of difficulties between parent and child. Attachment theory explains how the first six months are vital to establish an emotional bond between infant and caregiver (Bowlby, 1969). Children learn how to express emotions through the way their attachment figure responds to them (Bowlby, 1988). Once an attachment behaviour is developed it tends to persist and can determine how resilient or prone to mental health difficulties an individual will be (Bowlby, 1988). Depressed parents can find it difficult to interact with their infant; the baby gets used to a lack of positive interactions and learns to respond in a depressed manner (Gerhardt, 2004). As babies start to develop their independence they will check their care givers reaction to see

how they should be behaving. Therefore their attachment figure is their original source of social learning (Gerhardt, 2004). Social learning theory (Bandura, 1977a) explains how behaviour develops through an individual's experience of the environment, the consequences of their actions, and the reinforcement of behaviours. If an infant is experiencing poor emotional regulation in the household and their own maladaptive emotional regulation is reinforced they are likely to persist with that behaviour. Considering these theories parenting is likely to impact upon the development of the child's psychological health.

Depression in either parent may impact upon their child through the effect depression has on their interactions and parenting. In studies of paternal depression when the child is older paternal major depression has been found to be associated with less optimal father-child interactions (Bronte-Tinkew *et al.* 2007; Davis *et al.* 2011). Father's depression was also associated with father-child conflict which mediated the effect of father's depression on the child's externalizing symptoms (Kane & Garber, 2009). A recent meta-analysis found that depression has a significant, but small, negative effect on fathers' parenting (Wilson & Durbin, 2010). There are also interactions between depression in one parent reducing positive parenting behaviours in the other parent, and this was the case for both maternal and paternal depression (Paulson *et al.* 2006). Further research is required into the mechanism by which paternal depression impacts on the child, and treatments for paternal postnatal depression and the impact on the child.

Recommendations for future studies

Considering the strengths and weaknesses of these reviewed studies a future study may benefit from the following methodology. After initially using a power calculation to find appropriate sample size, and using a suitable sampling strategy which results in a nationally representative sample, a longitudinal repeated measures study could be conducted. It should assess paternal depression in the postnatal period by a clinical diagnostic interview and by using a valid and reliable measure such as the EPDS (Cox *et al.* 1987) or BDI (Beck & Steer, 1993, 1996). Child outcome measures should be taken which assess infant temperament, internalizing and externalising behaviours, psychiatric diagnosis, and a measure of intellectual abilities including language abilities. Measures should be valid and reliable and be completed by both parents to reduce reporter bias. Further variables should also be assessed using valid and reliable measures to determine moderating and mediating factors which effect the impact of paternal depression on child outcomes e.g. maternal depression, parenting style, parent's attachment style, child gender, the time a father spends with his child, quality of paternal relationship, and socio-economic status.

Summary

The clinical implications of these findings are paternal depression in the first year of life is likely to have detrimental effects on the child's psychological development. Therefore interventions to treat the father's depression should be considered for the benefit of the father and children. Further research could also be conducted to examine the effectiveness of paternal depression treatments on child outcomes.

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2. Bridging Chapter

The previous chapter systematically reviewed literature on paternal depression in the first year after birth and the effect on the child. The evidence supported an association between paternal depression and emotional regulation and behavioural difficulties in the child. The role of the father in child development has received the interest of scholars over the last 30 years (e.g. Lamb 1997a, 2010). Yet the role the father takes when the mother has postnatal mental health difficulties has been less widely investigated. Within this study the father's role when his partner and child are admitted to a Mother and Baby Mental Health Unit will be considered. This is an important area to study considering attachment theory research, as poor attachment can cause later emotional and behavioural problems. In this chapter literature on the father's role, their experience when their partner has postnatal mental health difficulties and the impact postnatal depression has on relationships will be presented. Factors which are known to affect attachment will also be discussed; these are parental mental health, the quality of the relationship between parents, and being separated from the baby. Finally, models of coping and resiliency will be presented.

2.1. A Father's Role

A new baby's arrival into a family is a time of significant change; parents need to re-adjust their roles in order to accommodate the newest member who requires almost constant soothing, feeding and changing (Fuligni & Brooks-Gunn, 2004). Over the past 50 years the role of the father in the western world is altering from one of a provider to a more nurturing role. In addition women's expectations of

fathers involvement has changed, with a greater expectation men will be more involved in child-care (Walters, 2011). These changing roles and expectations reflect social, political, cultural and economic trends (Day & Lamb, 2004).

The role of 'father' is diverse and fathers tend to take multiple roles within their family such as the bread-winner, a playmate, caregiver, and guide to their children. Individual fathers vary in how much importance they place on these roles (Lamb, 2010). In terms of childcare, the majority of childcare activities are done by the mother, although when mothers are employed the father's amount of involvement with his child compared to the mother increases, but this is only because the mother is doing less (Lamb, 1997a).

There is the idea in the literature that fathers are primarily playmates and mothers are caregivers (Roggman, 2004). However, this idea minimises both parent's relationship with their child. Fathers spend a larger proportion of their time playing with their child, but because mothers spend more time with the child the mother is actually playing with the child more (Lamb, 1997a). Play has an important role in bonding, stimulating the infant, and teaching social interaction (Lamb, 1997b). Lamb (1997b) explains both parents are capable of interacting sensitively with their infants and that social beliefs rather than biological imperatives underlie the traditional division of labour.

Among researchers in Britain there is increasing awareness that 'fathering' does not take place in isolation but occurs in interaction with mothers and children in

increasingly diverse sets of family alliances and household contexts' (Clarke & O'Brien, 2004, p.43.). The father's paternal role and relationship with his child is developed in conjunction with the mother (Marks & Lovestone, 1995; Pleck & Stueve, 2004). So the father's influence on his child must be considered in relation to the wider family context (Lamb, 1997a). Additionally, the father has an important role in providing emotional support to the mother which enhances the relationship between mother and child (Lamb, 1997a).

2.2. A Father's Experience when his Partner has Postnatal Depression

Several qualitative studies have investigated the father's experience when his partner has postnatal depression. For example Boath *et al.* (1998) found postnatal depression was placing a burden on partners financially and socially. Fathers also reported an adverse effect on their relationship and their own mental health. This study was limited by its lack of a detailed methodology, its discussion of the sample, and poor analysis. They described their findings as preliminary and recommended further research.

In a study by Meighan *et al.* (1999) eight fathers were interviewed about their experience of living with a partner with postnatal depression. In this American community sample fathers spoke of their losses; of the partner they had known and the relationship they had shared, they felt fear, and a loss of control. There was a determination to 'hold the family together' (p.206.) and a frustration they couldn't fix the problem. They experienced stress due to the increased demands on them. Losing the support of their partner during the transition to parenthood was difficult.

The clinical recommendation was to identify fathers suffer when their partner experiences postnatal depression and design interventions. The difference in the health care system in America as well as social and cultural differences makes it difficult to generalise findings to a UK population. The study was limited by the gap between the episode of depression and the interview being as great as 11 years.

Eight couples were interviewed by Webster (2002) to investigate whether men were affected when their partner had mild postnatal depression. The couples expressed poor understanding of how their partner felt. Postnatal depression placed an evident strain on their relationship. Six couples desired more information about postnatal depression and seven couples wanted the whole family to be seen together by professionals. One participant said 'she had the (postnatal depression) but it was our family, it involved all of us' (p.392). This study had a strong methodology but acknowledges that interviewing the father in the presence of his partner may have affected results.

More recently a small sample of Australian men '... experienced their partners' (postnatal depression) as overwhelming, isolating, stigmatizing, and frustrating.' (Davey *et al.* 2006, p.206.). Frustrations were related to their partner feeling hurt when the father enquired about childcare, and poor communication between the couple. Participants discussed the changing role of men in their society and their struggle to find their place between the views of their father's generation and their own. They felt pressure to make money and participate in childcare. Fathers were reluctant to ask for help and relied on friends for support. Results should be

taken with caution as participants had sought out and completed a group treatment programme for partners of women with postnatal depression, so they may have been struggling more than other fathers in the community. The cognitive behavioural therapy based group reduced father's stress and depression levels.

Taking the evidence presented maternal postnatal depression affects the couple's relationship, there are financial and social difficulties associated, and it can effect paternal mental health. Father's experience postnatal depression as affecting the whole family and they want the family to be considered as a whole by professionals. Crucially these studies are all from community samples where the mother is at home within the family, their experience may differ from the father's experience when his partner and baby are inpatients.

2.3. The mother's perspective on the father's role

One Canadian study has analysed women with postnatal depression's understanding of their partner's role. Results show women who perceived their partners as having greater availability in terms of physically being there and providing practical support, as well as emotional support, improved the mother's functioning and her self-appraisal as a mother. This study benefitted from a large community sample of women diagnosed with postnatal depression but was limited as it was a secondary analysis of interviews originally conducted to examine help-seeking. Furthermore, they did not investigate his role as a father in relation to his children (Montgomery *et al.* 2009).

2.4. Associations between severe maternal postnatal mental health and paternal mental health

The father in a family whose partner and child are admitted to a perinatal mental health unit appears vulnerable. There is very little research in this area. However, Harvey and McGrath (1988) found 42 per cent of fathers whose partner was admitted to the mother and baby psychiatric unit met diagnostic criteria for a psychiatric disorder compared to 4% of the control group. There was also an association with more social and marital difficulties. Similarly, Lovestone and Kumar (1993) found out of 24 men whose wives had been admitted to the postnatal psychiatric Mother and Baby Unit 50% had a psychiatric illness (depression, schizophrenia, and bipolar). This was higher than the percentage in a control group whose wives remained well after childbirth, and also higher than a group of men whose partners were admitted to a psychiatric ward for non-puerperal illness. Husbands of women in the Mother and Baby Unit had a similar rate of lifetime psychiatric disorder to husbands of women in the psychiatric ward (38% and 22% retrospectively). Of the 9 Mother and Baby Unit husbands with a lifetime psychiatric disorder, 8 developed a current episode of disorder when their wife became ill. At follow up it was found when the women recover so do their husbands. A limited amount of qualitative data was noted by researchers; the men discussed how there was a stark contrast between the excited anticipation of the baby's arrival and the reality of coping with an empty house, work, and visiting their ill wife. A feeling of sadness was emphasized by seeing the unused prams and toys when they returned home. This study benefitted from adequate control groups and a good yet small sample size. Importantly, this is the only study found which begins to investigate the

father's experience when his partner and child have been admitted to a psychiatric Mother and Baby Unit.

2.5. Maternal mental health; the impact on attachment, and the role of the father

Mothers are admitted to Mother and Baby mental Health Units because they either have current mental health difficulties or are vulnerable to postnatal mental health difficulties. When a mother is depressed she can find it difficult to respond to her baby, the mother can be withdrawn and apathetic. It can be hard for a depressed mother to engage in eye contact with their baby or to interact with them much beyond basic feeding and cleaning. This leads babies to get used to a lack of positive interactions and interact in a depressed style (Gerhardt, 2004). In contrast when a mother is anxious she may be over-involved with the baby and continuously stimulating them, this can result in the baby being over-aroused and feeling like they, and their caregiver, have no control over their feelings (Gerhardt, 2004). These mother-infant interactions do not lead to the development of a secure attachment style or good emotional regulation. One study which supports this is Murray *et al.* (1996). They found maternal postnatal depression negatively affected how sensitively attuned a mother is to her infant, and predicted poorer infant attachment. This disturbance in sensitivity predicted poorer infant cognitive ability. This UK study has a strong sampling method, valid and reliable measures, a comparison group, and researchers blind to the participants group. If a father was also suffering mental health difficulties it may contribute to an impact on father-infant interactions in a similar manner.

When the mother has postnatal mental health difficulties the father may need to take a greater role in supporting his partner and her bond with their infant. As Mantymaa *et al.*'s (2006) study found when the mothers had mental health problems a poor, disengaged marital relationship was associated with poorer interactions with her infant. This shows the father's role as a partner may affect the mother-infant interactions.

2.6. Maternal mental health; the impact on father-infant interactions

Few studies have investigated how father-infant interaction is affected when the mother is depressed. Goodman (2008) studied the influence of maternal postpartum depression on fathers and identified factors associated with father-infant interaction in 128 families at 2 to 3 months postpartum. Approximately half the families included women with significant postpartum depression symptoms. The study found maternal postpartum depression was associated with greater paternal depression and increased paternal parenting stress. Moreover, when the mother was depressed the father displayed less optimal interactions with their infants; in this study fathers do not appear to compensate for the negative effects maternal postnatal depression can have on the child. The father-infant interaction was influenced more by how the mother felt about her own relationship with the infant, than maternal depression. The way mother-infant and father-infant interactions are developed appears to be a complex interaction between the whole family.

2.7. Formation of attachment relationships

Bowlby's (1969) attachment theory explains the impact of the emotional bond between a caregiver and a child on the child's psychological development. An infant's attachment behaviour develops in the first months of life and its purpose is to keep the child in close proximity to its primary caregiver (Bowlby, 1988). The first six months after birth are crucial to establish this bond between caregiver and child with the majority of infants displaying attachment behavior by this age, although some take up to 12 months to display it (Bowlby, 1969). Once a pattern of attachment is developed it tends to persist, so as the child gets older he tends to use his style of relating in new relationships he forms (Bowlby, 1988).

The literature on attachment is almost entirely built on the mother-infant relationship (Condon *et al.* 2008) and has been criticized for ignoring father-infant attachment (Ayers & Wright, 2007). One influence on this may be Bowlby (1988) who said '...it seems likely that, at least during the early years of an individual's life, the model of self-interacting with mother is the more influential of the two. This would hardly be surprising since in every culture known the huge majority of infants and young children interact far more with the mother than with the father.'(p.145). However, Bowlby (1969) was clear that fathers are the second most frequent person to elicit attachment behaviours from infants, followed by older children within the family.

Children can show the same or different attachment behaviour towards their mother and father (Van Ijzendoorn & De Wolf, 1997). The attachment pattern with

the father will develop in the same way as it does with the mother; through the way the parent interacts with the infant (Bowlby, 1988). Lamb (1977) observed infants interacting with both their parents during their first year. He found infants were clearly attached to both parents and did not show an attachment preference for either parent. A small number of studies have investigated paternal-infant attachment. Wong *et al.* (2009) found fathers who viewed their caregiving role as important were more likely to have a securely attached infant (aged 12 to 13 months). Habib and Lancaster (2010) found that father's attachment to their unborn child increased as the due date approached. The study adds evidence to a relatively unexplored area but should be taken with caution as the study had a sampling bias and large drop out.

Whether a father establishes an attachment relationship with his baby will affect how the baby feels. When an infant is securely attached to a caregiver and they are together they feel secure and relaxed, however if they leave the infant will feel anxious, sorrow at their loss, and anger. They will cry in an attempt to maintain proximity to them and will be preoccupied by their attachment figure's whereabouts (Bowlby, 1969). However, if the opportunity to form an attachment is not available (e.g. due to separation) when infants are aged six to nine months they are likely to respond to strangers with a fear response. That response is stronger the older an infant becomes. Because of this fear response, it becomes increasingly difficult to develop an attachment relationship with a new figure towards the age of 12 months (Bowlby, 1969).

2.8. Attachment and mental health

The availability of a continuous, warm and intimate relationship between a mother and her infant is essential for the child's mental health (Bowlby, 1969). Bowlby (1988) explains within the first years of life children build working models of each attachment figure and their way of communicating and behaving towards the child. They also construct a complementary model of themselves which guides expectations of how attachment figures will treat them. Children learn how to express their emotions or not through the way their attachment figure responds to them. It is this aspect of attachment theory which differentiates between an individual developing a resilient personality or becoming prone to mental health difficulties such as anxiety or depression.

‘By the age of 12 months there are children who no longer express to their mothers one of their deepest emotions or the equally deep-seated desire for comfort and reassurance that accompanies it.’ (Bowlby, 1988, p.149.). This is a sign of insecure attachment.

Attachment behaviour occurs throughout the lifespan, when an individual is stressed or anxious they are likely to desire care from an attachment figure, such as a pregnant woman seeking care from her partner or mother. When they feel secure they will be able to seek and receive help. However, if a child is not securely attached their pattern of interaction with others can persist into later life and negatively affect new relationships (Bowlby, 1988). This is more likely to lead to difficulties with mental health as they will have difficulties within relationships and in times of stress will have difficulties requesting or accepting help.

2.9. The importance of relationships

During the transition to parenthood partner relationships are important in the psychological adjustment to the role of being a parent (Figueiredo *et al.* 2008). As discussed above, fathers feel their relationship is under strain when their partner has postnatal depression. Men and women with poor partner relationships are significantly at risk of depression during the first year of being a parent (Matthey *et al.* 2000). This high quality study used reliable and valid measures of depression and relationship quality at several time points. It is limited as its participants were more highly educated than would be expected in the population. Furthermore, Bradley *et al.* (1997) suggest the father's emotional investment in their child is related to the quality of their relationship with their partner. And that both relationships with partner and child will be influenced by their own attachment style.

2.10. Paternal involvement and attachment

No studies have investigated paternal involvement when mother and baby are in a perinatal unit. Lamb *et al.*'s (1985) model of paternal involvement conceptualises father's involvement as being comprised of three components; his interaction with his child, how available he is, and the amount of responsibility he takes in their care. It is likely these components are affected during an admission to a perinatal unit, particularly if the family live a long distance from the unit. Based on Lamb *et al.*'s (1985) model, Brown *et al.* (2012) hypothesised father involvement and sensitivity would affect father-child attachment security. They found the quantity and quality of early fathering was related to attachment security at 3 years, with greater involvement and sensitivity being related to more secure attachments.

However, when fathers interacted sensitively the amount of involvement no longer had an effect. The results should be interpreted with caution as the study has several limitations in how data was collected.

2.11. Theories important in understanding the fathers experience

Further theories which assist the understanding of a father's experience when his partner has severe postnatal mental health difficulties resulting in an admission to a Mother and Baby Unit will be presented. The cognitive relational theory of emotion and coping explains how cognitive appraisal of a situation and resulting coping mechanisms impact on emotion (Lazarus & Folkman, 1987). Individuals have attributions, such as goals, which affect their vulnerability to various situations, such as threats to a partner's well-being or the family's cohesiveness. However, the intensity of an emotional reaction varies dependant on the individual's coping mechanisms and personality factors. When the situation is relevant to the individual's goals then the emotion they experience will vary in intensity dependent on what is at stake. Whether an individual believes they are powerful or helpless to effect a situation alters their decision of whether they have a 'stake' in the situation. The higher the stakes are judged to be the more the individual should mobilise coping behaviour. Secondary appraisals are made when the individual evaluates whether they can improve the situation, and what coping strategies might be implemented. Consequences of the implemented coping strategy can alter their appraisals and affect their emotional response. When people are confident in their

abilities they are less likely to appraise situations as threatening, and more likely to use effective coping strategies (Lazarus & Folkman, 1987).

An individual's belief in their abilities, termed 'self-efficacy' determines their choice of behaviour, the amount of effort they apply, and their persistence when trying to cope in stressful situations. Self-efficacy is developed through their own performance accomplishments, vicarious experience such as learning through modelling, verbal persuasion that they can cope successfully, and emotional arousal. High levels of anxiety usually debilitate performance depending on the cognitive appraisal of anxious symptoms (Bandura, 1977b).

The resiliency model of family stress, adjustment and adaption (McCubbin & McCubbin, 1993) captures how families respond to illness. The model explains how illnesses in the family can cause family crisis and triggers the family to adapt and change. The model takes into consideration stressors, hardships, and demands the family experiences when one member becomes ill and the family's appraisal of the situation. It recognizes the family's use of resistance resources (such as social support), and its coping strategies, which lead to adaptive or maladaptive coping.

2.12. Clinical implications

Considering the literature, professionals working clinically with mothers with postnatal illness should consider the father's role within the family, and the impact of the postnatal illness on him. The relationship between the couple may be strained. The father may require psychological support at this time. The experience of

postnatal mental illness appears to effect interactions between parent and infant, this is particularly concerning considering the effect it has on the development of attachment relationships and the sequential effect on psychological health. Intervening to treat the parent's difficulties could have a positive impact on the child's development. Understanding the father's (and the family's) difficulties and how they cope during the mother's illness may help to tailor an intervention to their needs.

3. THESIS AIMS

There are two Mother and Baby Mental Health Units in central Scotland providing assessment and treatment for severe postnatal mental health difficulties such as depression and puerperal psychosis. These 6 bedded wards provide an inpatient service for the whole of Scotland and are available for mothers with infants under 12 months of age. The services are designed for the care of mothers and babies, not for fathers. The services have encouraged this study as they are interested in fathers' inclusion, and developing an evidence base for service provision.

When a mother is suffering from a severe postnatal mental illness it is a time of risk for both the father's mental health and the baby's psychological development.

Previous research has investigated the impact of maternal postnatal depression on the father in community settings but not in an inpatient setting. An admission to the Mother and Baby Unit not only aims to treat the mother but strengthen the mother-baby bond. The effect on the father's role and his ability to bond with the baby has not been researched previously, and beginning to understand his role could contribute towards supporting these families and the child's development.

The main research question is:

- What is the father's paternal role and how does he develop his relationship with his child when his partner and child are admitted to a Mother and Baby Mental Health Unit.

Secondary questions are;

- What is the father's experience of his partner and child being in the unit?
- How could fathers be supported?

4. METHOD

4.1. Design

Qualitative research can be a useful tool for learning about a person's experience with a phenomena, uncovering what lies behind a phenomenon, and gaining fresh insights into something which little is known (Strauss & Corbin, 1990).

This study utilised the qualitative Grounded Theory design to guide the interview and analysis process. Grounded theory was originally developed by sociologists Glaser and Strauss (1967) although more modern versions have deviated slightly from this classic theoretical background they still retain the basic guidelines e.g. sampling for theory development, coding and memo-writing (Charmaz, 2006). The purpose of Grounded Theory is to create a theory which illustrates, and remains faithful to, the area which is being studied (Strauss & Corbin, 1990). Grounded theory starts with an area of study, and then concepts are discovered, developed and verified through the systematic collection and analysis of data to create a theory (Strauss & Corbin, 1990). The Grounded Theory method generates concepts whilst also testing the relationships between them (Strauss & Corbin, 1990). It is unique in the way it moves back and forth between gathering data, coding and analysing before returning to gather more data to answer further queries. Through engaging in the research processes of the Grounded Theory method it enables researchers to retain control of the research process and gives greater analytic power to the results (Charmaz, 2006).

This study used the more recent version of Grounded Theory by Charmaz (2006) this approach assumes that a theory is an interpretation of the studied world constructed by the researcher. The researcher's background, their questions and decisions are clearly acknowledged as contributing to the resulting theory in Charmaz's version of grounded theory (Willig, 2008). It was therefore important to remain aware of what the author's preconceived ideas were and be cautious about the impact they would have on the resulting theory, this "reflexivity" will be discussed later. This chapter will illustrate how recruitment, data collection, and data analysis was conducted guided by the Grounded Theory method.

4.2. Procedure

4.2.1. Recruitment of Participants

Meetings were held with key members of staff at the two national Mother and Baby Mental Health Units in Scotland. Staff were given details of the study, including inclusion and exclusion criteria, and asked to identify potential participants. An information sheet (appendix 1) was distributed for reference and the researcher was available to answer any questions.

4.2.1.1. Inclusion and exclusion criteria

Inclusion criteria:

- Fathers of infants admitted to the Mother and Baby Unit during the time of recruitment, or within the previous 12 months.
- The father must have visited their partner and child in the unit.
- The father must be over 18 years old.

- The infant will be under 12 months old when admitted.
- The father must be fluent in English.

Exclusion:

- Experiencing a high level of distress.

There were two separate methods of recruitment for the interviews; one to recruit fathers whose partner was no longer in the unit and one to recruit fathers whose partner was currently in the unit.

4.2.1.2. Fathers whose partner was currently in the unit

Nursing, psychiatry and psychology staff approached suitable participants in the unit, provided an information sheet (appendix 2), and asked if he wished to participate. Positive responses were followed up by the researcher to arrange an interview. Due to some fathers variable visiting times not all fathers were available for nursing staff to ask, so these fathers were posted the study information instead. An interview was arranged with the researcher at least 24 hours after the father agreed to participate.

4.2.1.3. Fathers whose partner was no longer in the unit

The researcher had Caldicott Guardian Approval to access patients' addresses in one of the recruitment bases. From the admission records for the one year and 121 day long recruitment period nursing staff identified all women whose partner met the inclusion/exclusion criteria. All suitable potential participants (who had not been recruited in unit) were sent the study information sheet (appendix 3) with a reply slip

and self-addressed envelope. The researcher then contacted interested participants to arrange an interview in a convenient NHS location.

4.2.1.4. Recruitment Numbers

Recruitment base 1.

Numbers of admissions between 1st February 2011 and 18th June 2012 = 97.

Numbers in a relationship with the baby's father = 67.

Of those admissions 11 were re-referrals. There were therefore 56 possible participants. Five fathers were excluded as 2 were deemed too distressed, and 3 admissions were overnight stays where the father did not visit. Fifty-one fathers were invited and 8 agreed to participate.

Recruitment base 2.

Numbers of admissions between 9th May 2012 and 18th June 2012 = 6.

Number in a relationship with the baby's father = 4. All were invited and none agreed to participate.

4.2.1.5. Participant characteristics

Participants were eight fathers whose partners were, or had been, admitted to the Mother and Baby Unit. They were aged between 28 and 51 years (mean = 37.5, standard deviation (s.d) = 8.14) and all were married. For three participants their wife was an inpatient during the interview. Five participants were first time fathers, two participants had one older child, and one participant had two older children. Six participants were of White Scottish ethnicity, one participant was of White Other

British ethnicity and one participant was of Black African ethnicity. Six participants were employed full time, two participants were self-employed. Participants occupations were classified as Managers (1 participant), Professionals (1), Technicians and Associate Professionals (4), Service Workers (1), and a Craft and Related Trade Worker (1) as assessed by the International Standard Classification of Occupations (1987) document ISCO-88. All participants' depression, anxiety and stress scores were within the 'normal' range as measured on the Short Form version of Depression Anxiety Stress Scales (DASS-21; Lovibond & Lovibond, 1995a). The mean depression score was 1.25 (s.d = 2.12). The mean anxiety score was 0.5 (s.d = 0.93), and the mean stress score was 5.25 (s.d. = 4.53). The cut off scores for 'mild' distress on the DASS-21 are; 10 for depression, 8 for anxiety, and 15 for stress.

4.2.1.6. Theoretical sampling

In Grounded Theory "theoretical sampling" is used. Theoretical sampling allows the researcher to seek out sources of data which will help elaborate and refine categories which have been identified in earlier data. Its purpose is for theoretical development (Charmaz, 2006). Therefore, in this study once some of the initial interviews have been analysed and 'categories' have been identified the recruitment of subsequent fathers can be focussed to those who may be able to elaborate categories. For example, the researcher may wish to recruit fathers who have several children if it becomes apparent that 'caring for other children' is a category which requires further investigation. The nurses in the unit would be able to advise the researcher on which fathers may represent certain categories.

4.2.1.7. Saturation

In Grounded Theory the researcher stops recruiting participants and collecting data when the categories are "saturated". Categories are "saturated" when collecting fresh data no longer creates new theoretical insights, or reveal new properties of the core theoretical categories (Charmaz, 2006). It is therefore difficult to put an exact number on how many participants will be required.

4.2.2. Data Collection

Grounded Theory emphasises the simultaneous collection of data and its analysis, as the researcher moves back and forth they create an analysis of action and processes, the data collection is shaped to inform the emerging analysis (Charmaz, 2006).

4.2.2.1. DASS-21

The DASS-21 (Lovibond & Lovibond, 1995) see appendix 4, is a valid and reliable measure of depression, anxiety, and stress (Henry & Crawford, 2005). Tested on a large non-clinical sample the DASS-21 was found to have good to excellent internal consistency with chronbach alpha scores ranging between .82 and .93 for Anxiety, Depression, and Stress. The DASS-21 has good convergent and discriminant validity when compared to validated depression and anxiety measures (Henry & Crawford, 2005).

4.2.2.2. Demographic Information

The demographic form (appendix 5) took 5 minutes to complete and recorded age, number of children, marital status, ethnicity, and occupational status.

4.2.2.3. Interviews

One-off, individual interviews were conducted with fathers and recorded. Intensive interviewing is useful for in-depth exploration of a particular experience (Charmaz, 2006). By using intensive interviewing the researcher exerts greater control over the construction of data than they would using other methods for example ethnography (Charmaz, 2006).

“The combination of flexibility and control inherent in in-depth interviewing techniques fit grounded theory strategies for increasing the analytic incisiveness of the resultant analysis” (Charmaz, 2006, p.29.).

As directed by Charmaz (2006) the interview questions needed to be designed to gather rich data and at the same time avoid imposing preconceived ideas on it. The initial interview contained open ended, non-judgemental questions which allowed the participants stories to emerge, for example “Tell me about your experience of your partner and child being in the Mother and Baby Unit?”, “How do you spend your time during a visit?” and “Would you like anything to be different in the unit?”.

During and after each interview, questions were reviewed, and new questions were developed to explore topics and themes which required further clarification. In this study interviews were transcribed, analysed, and new questions created before the next interview was conducted.

Interviews ranged in length from 49-103 minutes (mean 69 minutes).

4.2.2.4. Overview of meetings with participants

Interviews were arranged in a NHS location convenient to the participant such as clinic space used by the local psychology department, or in the Mother and Baby Unit. The participant was given the participant information sheet to read for the second time. They were given the opportunity to ask questions before completing the consent form (appendix 6) if they wished to proceed. Then the participant was given the Helplines and Crisis Support sheet (appendix 7) and completed the Demographics form. Finally they completed the DASS-21 before the interview commenced. After the interview they were again given the opportunity to ask questions. Participants were asked whether they wanted to be contacted at a later date to go through a copy of their transcript and discuss categories that the researcher had identified. The researcher met one participant to do this.

4.2.2.5. Transcription

The interviews were transcribed by the researcher using Microsoft word. For Grounded Theory analysis it is sufficient to transcribe what is being said, so the words, rather than the non-linguistic features of speech such as length of pauses and volume of speech (Willig, 2008). Identifiable information such as names, occupations, and identifiable locations were not transcribed. All interviews were transcribed in full; an excerpt of one transcript is included in appendix 8.

4.2.2.6. Memos

“Memoing is what makes theory grounded” (Birks & Mills, 2011, p.181.).

Keeping frequent and insightful memos are an integral part of the grounded theory process. Memos are informal analytic notes which record, chart and detail analytic steps and discoveries. They help the researcher keep engaged with the data and to develop ideas. They also help illuminate gaps in the analysis. Essentially the researcher’s memos are central to the resulting grounded theory (Charmaz, 2006).

The lead researcher therefore recorded her own thoughts and observations during the course of the study in a personal journal. Memos were made on thoughts about interviews, the recruitment, my own prior expectations, the analysis and any other aspects of the research that came to mind. This information forms part of the data set, was integrated in analysis, and is discussed in the personal reflection section.

4.2.2.7. Reflexivity

Reflexivity is “an active, systematic process used by the researcher in order to gain insight into their work that will guide future actions and interpretations.” (Birks & Mills, 2011, p.175.). It is a way for the researcher to scrutinise their experience of the entire research process and their impact upon it. There is an obligation for reflexivity to be incorporated into constructivist grounded theory and memos should capture reflective thoughts about the research process (Birks & Mills, 2011). However, in order to make a memo reflexive it is important to write about the *impact* and *outcome* of your thoughts and actions (Birks & Mills, 2011).

One issue that could affect the results and should be reflected upon is the researcher being female and interviewing males. Arendell (1997) reflected on how she as a woman impacted on the interviews she had with divorced men. She found fathers were less concerned with the relationship with their children and more concerned with their identities as adult men. They made their masculine identity apparent to her through their interactions with her in the way they were assertive, controlling and rational. In spite of this most participants expressed they had been cautious not to disclose their feelings to other men as they believed men would be more critical of displays of emotion and they had shared their deepest feelings with her. In this study the researcher should remain aware that gender issues could affect the interview process and be aware of transference issues between the participant and themselves. Another issue could be the researchers preconceived ideas of what fathers should do in the unit. Although the researcher had visited the Mother and Baby Unit they did not work there, they had some ideas of what may happen there but felt by not working there their perception of what happens was free and open and this facilitated seeing things from the participant's perspective. The researcher aimed to work reflectively throughout the study.

4.2.3. Data Analysis

Data is continuously analysed in Grounded Theory. In this study after each interview was done it was transcribed and analysed before the next interview was conducted.

4.2.3.1. Coding

Coding in Grounded Theory allows the researcher to take a moment to ask analytic questions about the data that has been gathered; this not only increases understanding of the studied experience but also directs further data collection. A researcher using grounded theory will return to the data again and again to complete initial and focused coding. In initial coding the data is studied closely, words, lines and segments can be coded by applying a name to it. Later focused coding is used to explore useful initial codes and test them against other data. It is a constant process of comparison (Charmaz, 2006).

Within this study line-by-line coding was initially used. Line-by-line coding is often the first step, it can help spark new ideas to pursue, and it helps to correct against the likelihood the researcher will superimpose preconceived notions on the data (Charmaz, 2006). Secondly, focused coding was used to synthesize and explain large segments of the data. This is done by making decisions about which initial codes are most relevant and using that information to sift through large amounts of data. Finally, theoretical coding completes the coding process. Theoretical codes are applied to explain relationships between categories and they create a more coherent analytical story. It is a way of integrating the data back together after it has been fractured by the initial coding process. Theoretical codes can add clarity and coherence to the analysis. During theoretical coding it is important to question

qualities of the codes such as; what causes them, in what context do they occur, what are the contingencies and consequences of the action being coded, what are the covariates and the conditions in which the action occurs. It is important to use theoretical coding to make the analysis objective but it is important to not impose a forced framework on the analysis (Charmaz, 2006).

Coding is a dynamic process in grounded theory, data is revisited and categories reconsidered as more data is collected. Constant comparative methods must always be used to analyse comparisons and distinctions between the data. Careful coding also helps guard against the researcher putting their own experience and opinions onto the data (Charmaz, 2006). In this study once several transcripts were complete they were re-read and re-analysed applying higher level categories derived from the initial coding. Several transcripts were given to supervisors to code and compare ideas about emerging themes. This helps eliminate any bias of the researcher's experience affecting the analysis. The emerging themes were compared to relevant literature to strengthen the credibility of the themes.

4.2.3.2. DASS-21 and Demographic form

Results from both the DASS-21 and demographic forms provided descriptive statistics about the participants.

4.2.4. Data Management

4.2.4.1. Confidentiality

All participants were assigned a participant number. Recordings, interview transcripts, DASS-21 forms, and demographic forms were anonymous and only identifiable by their participant number. Consent forms contained identifiable information and were stored separately.

4.2.4.2. Data storage

Recordings were stored on an encrypted data storage device and on NHS password protected computers. Transcripts, DASS-21 forms, and demographic forms were stored in locked filing cabinets on NHS property, as were the consent forms which were separated from the other data. Participant addresses and contact details were stored in locked cabinets or on NHS password protected computers until their participation in the study was complete, the data was then deleted, or shredded and disposed of in confidential waste. NVivo computer software was used to store and organise the analysis of data.

As per the Modern Humanities Research Association (MHRA) guidelines personal data e.g. consent forms must be archived for 5 years. Therefore all data will be stored securely for 5 years before destroying it by shredding it and disposing of it in confidential waste or deleting it.

4.3. Ethics

The study received ethical approval from the South East Scotland Research Ethics Committee (appendix 9). Caldicott Guardian approval was granted to access names and addresses of patients who had been admitted to one Mother and Baby Unit in the previous year (appendix 10).

4.3.1. Informed consent

Fathers were given a minimum of 24 hours to consider participation in the study after being given the information sheet. Participants were informed participation was voluntary, that it would not affect their partners care, and that they were free to withdraw without having to give a reason. If a participant wanted to withdraw their data at a later date prior to the analysis and write up, their participant number would be used to find their recording, data, and transcript which would then be removed from the study.

4.3.2. Risks to participants

Participants could have felt distressed during or after interviews. As a Trainee Clinical Psychologist the researcher was used to discussing distressing topics with patients and was able to calm the participant and put them at ease when necessary. Contact details for mental health organisations were also supplied so participants could seek support after the interview. Participants could have disclosed something which posed a risk to their child. As a Trainee Clinical Psychologist the researcher was bound to report child protection issues as per health board policy and procedures. Participants were made aware of this before commencing the interview.

4.4. Quality in Grounded Theory research.

Charmaz (2006) outline four criteria for evaluating Grounded Theory research. These are credibility, originality, resonance and usefulness. When a research project has a strong combination of originality and credibility it has a greater amount of resonance and usefulness and is therefore a more valuable contribution to the field.

4.4.1. Credibility

Credibility is obtained through familiarity with the phenomenon of interest, collecting a sufficient amount of data which has breadth and depth, making systematic comparisons between data and categories, having categories that represent a wide range of observations, having strong links between data and the resulting analysis, and finally providing enough evidence for a reader to form an opinion in line with the researcher (Charmaz, 2006). One of the ways of recording and illustrating this process is through writing memos, which has been done in this study.

4.4.2. Originality

Originality requires the categories generated to be fresh and provide new insights. The analysis should provide a new understanding of the data. The work should be of social and theoretical importance. To be original the research should impact upon current ideas in the field either by extending it, challenging, or refining existing ideas or practices (Charmaz, 2006). This study was the first to investigate the fathers experience when his partner and child are in the Mother and Baby Mental Health Unit.

4.4.3. Resonance

Resonance is achieved when the categories truly portray the full experience of the phenomena under investigation, this illuminates taken-for-granted meanings and takes into account the larger influences on individuals lives. When a study has resonance the resulting theory will make sense to the participants and people who experience that phenomenon (Charmaz, 2006). To improve validity feedback can be obtained on the study's findings from participants (participant validation), the participant's response is then incorporated into results (Mays & Pope, 2000; Willig, 2008). In this study the researchers coding was compared to supervisors coding and the categories were discussed with one participant, his responses influenced the final results.

4.4.4. Usefulness

Usefulness of a Grounded Theory research project is judged on whether the resulting analysis offers interpretations which could be used to understand their everyday experience. Have any generic processes been highlighted which could have more far reaching implications? If the study generates further research in other areas, contributes to the knowledge base, or in a way makes things easier for people experiencing the phenomena then it is regarded as useful (Charmaz, 2006). If the research adds to the research base or improves on existing knowledge and can be generalised beyond the setting in which it was conducted then it can be regarded as having relevance and being of greater quality (Mays & Pope, 2000).

4.4.5. Other processes to increase validity

In order to improve validity attention should be given to data which contradicts the emerging explanation of the phenomena, so that the final analysis is able to explain the majority of participants experiences (Mays & Pope). Furthermore, the researcher working reflexively improves the validity of qualitative research. The researcher should scrutinise the research process, be sensitive to their own role and how they could influence the process of research and the results due to their prior assumptions and experience (Mays & Pope, 2000; Willig, 2008).

4.4.6. Audit trail

The maintenance of an audit trail is a key strategy to uphold quality in a grounded theory study (Birk & Mills, 2011). Memos are one way of maintaining that audit trail. As is the use of a software package such as NVivo utilised in this study.

5. RESULTS:

5.1. MANAGING THE SELF AND OTHER RELATIONSHIPS

The birth of a baby into a family is a time of transition. When this is interrupted by an illness and an admission into hospital this transition is disrupted. There was a clear acknowledgement by fathers that their partner having postnatal mental health difficulties was challenging for the whole family. The mother and baby becomes detached from the family and incorporated into a new network of caregivers. The fathers have little understanding or ability to control the situation. There was a sense that if they could understand and manage their own experience and stay strong, they would be able to manage the changes in their family relationships incorporating the illness and inpatient admission.

The overall category which encompassed the participants' narratives is 'Managing the Self and Other Relationships'. This captures the father's experience and how he tries to understand and manage it, and the role he takes in relation to making and maintaining bonds within his family. The subcategories are Bonding with Baby, Keeping the Family Together, Feeling Contained, Feeling Overwhelmed, and Experiencing and Managing Uncertainty, see figure 2.

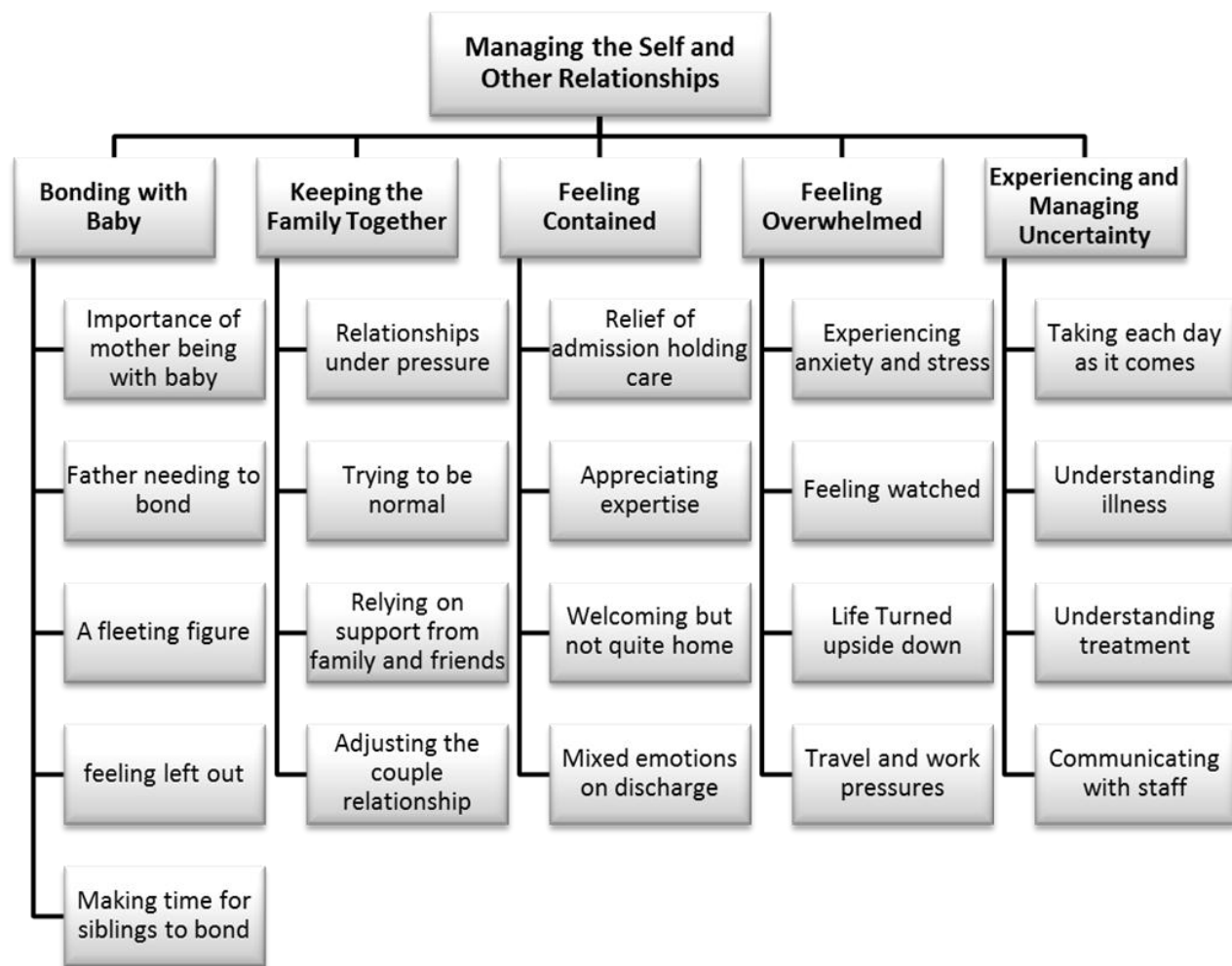


Figure 2. Categories of Managing the Self and Other Relationships; a fathers experience when his partner and child admitted to the perinatal mental health unit.

5.1.1. Bonding with Baby

Establishing an attachment bond between an infant and its caregiver is essential in the first six months to a year (Bowlby 1969). These categories capture the father's desires for the whole family to bond with the baby during this time when bonding is under jeopardy due to separation and mental health difficulties. These categories capture how the father manages his own and other family members' relationship with the baby.

5.1.1.1. Importance of mother being with baby

The fathers' strongly emphasised the importance of the mother being with the baby. They felt it was essential they were together for the well-being of both mother and baby, and were reassured by them being together. The significance of this bond was emphasised by having a mental health unit specifically designed to keep them together.

"I'm not sure what the evidence is here, or the factual information but ...I don't know if it is an old-fashioned thing to say but I do think there is a bond between a mother and a child, a baby and its mother. And I think there must be in a sense. Surely that's why there is a mother and baby unit" (Participant 2)

For many fathers this idea resulted in them aiming to strengthen and preserve the bond between their partner and their baby, sometimes to the extent that they would reduce the frequency and intensity of their own interactions with their infant.

"I think I was a bit cautious in the early days when I first started going down to Livingston. Maybe in some ways thinking to myself ...I suppose I did actually in the early days...thinking how important it was for (partner) and (baby) to be together" (Participant 2)

This restriction of their own interaction with the baby occurred even though they were clearly spending less time with the baby than the mothers. Fathers did not want to overshadow the importance of the mother-baby bond, particularly when a mother felt anxious about her abilities as a mother. When a father felt his partner wanted him to be involved in childcare he would become more involved in order to help her, such as allowing her to rest. The findings regarding the importance of the mother being with baby reflects the traditional view that mothers would generally be with the baby more, as they provide the majority of childcare (Lamb, 1997a). By retaining

a continuous relationship between them it also supports the formation of a secure attachment between baby and mother which is beneficial to the child's mental health (Bowlby, 1969). Fathers are supporting this bond by nurturing the relationship between mother and infant. This finding has implications for Mantymaa *et al's* (2006) study where a disengaged couple relationship was associated with poorer mother-infant interactions; in a disengaged relationship fathers may not be sensitive to the mothers needs to bond and preserve their bond as fathers in this study do. Furthermore, it shows the fathers' interactions with the baby are influenced by his beliefs about the mother infant interaction which resonates with Goodman's (2008) findings that the father-infant interaction was influenced more by how the mother felt about her own relationship with the infant, than maternal depression.

5.1.1.2. Father needing to bond

Fathers clearly wanted to bond with their baby, they wanted to get to know them, and meet their needs. Whether this bond was being created or not caused concern for fathers, particularly when they experienced long admissions and were unable to visit frequently. Being sensitive to a baby's needs and responding appropriately is essential in forming secure attachments, but being absent from the baby will affect the formation of attachments (Bowlby, 1988). Fathers were sensitive to this.

“As much as she obviously recognises me. Erm it does still worry me that, obviously because I have been away for so long but I can see she recognised. Being away working for so long and being back, will she still remember me as a dad? ...She has still remembered. And I have known since first of all. My wife said do you see how she has reacted to me (father) differently to any of the other nurses in here.

So your wife sort of reinforcing...

Yer. So (partner) emphasises that my daughter remembers me, she remembers her dad. Because as much as a 6 month old knows what a daddy is she recognises me as that most significant man in her life.” (Participant 5)

Participant 5's partner had perceived his concerns and the reassurance she gave appears to have strengthened his sense of a bond with his baby. Fathers who felt encouraged to interact with their babies by their partners spoke of doing more caregiving. Perhaps the partner's encouragement was incorporated into the father's self-efficacy (Bandura, 1977b) of their abilities to provide care and resulted in them doing more. Fathers thought trying to bond was something any new father would do irrespective of whether their baby was in hospital. For fathers who experienced short admissions to the unit there was a sense that bonding could be put on hold until everyone returned home.

“I suppose doing what any new dad does you want to get to know your baby and work out what baby needs and...although thinking back to that time I think probably all of that, trying to start bonding with baby and so on, probably all started when we got her home.” (Participant 3)

Fathers enjoyed interacting with their baby, and therefore missed their baby when they were unable to visit frequently over long admissions.

“So yer it's just making faces, smiling at him, and things like that. Yer just playing with him, making sure I hold him as much as possible really. Because I find I tend to miss doing that when I am away.” (Participant 7)

All fathers spoke of practical child care tasks they did in the unit. For new fathers with limited experience of childcare many of these tasks were new experiences and tuition from staff was appreciated.

“I have been helping with feeding, changing, I gave him his first bath yesterday. The staff are obviously geared towards tuition.” (Participant 6)

By modelling how to provide care the staff are providing a learning opportunity, again this can become incorporated into the father’s self-efficacy of his ability as a caregiver (Bandura 1977b). Once established, self-efficacy tends to generalise to other situations, so if modelling was done successfully the father is more likely to implement caregiving at home.

5.1.1.3. A Fleeting Figure

Fathers expressed a concern about being perceived as a ‘fleeting figure’ by their baby. They wanted to visit as much as they could and be involved in care giving so their baby could grow to know them. Again this absence would impact on the successful formation of an attachment relationship. There was a sense that they were not able to be the stable figure sitting with their child for hours as they might at home, because they were restricted in terms of how long they could spend visiting.

“I would maybe do the feed at that point.

How did that feel?

It was always good to do. Felt as though you were being involved in the baby’s life rather than sort of this fleeting figure that rushes in and out every so often. So that was good.” (Participant 1)

How fathers appraise a situation impacts on the coping strategies they use and their resulting well-being (Lazarus & Folkman, 1987). Caring for the baby combated that concern of being a fleeting figure when they were in the unit. When fathers were aware they weren't visiting often, they reassured themselves with the idea that their infant may be too young to really notice their absence. Several also felt the baby was too young to interact with much until the baby becomes more active at around 6 months old. These beliefs seemed to help them cope with not seeing the baby much, but for long admissions the worry loomed that their baby may not recognise them as someone who is an important figure in their life.

"Whether it be this is someone I see an awful lot, this is someone I don't. But having said that, that is something I am not worried about, but I have in the back of my mind. I don't want to use the word worried but it's close to worry in a sense. I won't want him to be here till he gets to that sort of age where he and I begin to sense some funny feelings from him. Or he sees me and he sees me as the one who's scaring him or something like that for the first few minutes. You know what ever, basically I don't want him to grow, I don't want him to get to the point where he is spending more than half the week not seeing his dad." (Participant 7)

Although 0 to 3 month old infants may appear limited in their interactions due to their sensory and motor skills being in early stage of development it is an important time for the infants to be stimulated (Carr, 2006). Infants are totally reliant on their caregivers and the process of learning whether a caregiver responds to their needs is already happening and can be established by 6 months (Bowlby, 1969). The fathers in the study are handling any worries they have about separation from their baby by putting them on hold. They are reassured by mother and baby being together and are waiting out the admission until the family return home.

5.1.1.4. Feeling left out

Unless the fathers were able to visit frequently over a short admission there was a clear sense of feeling left out, of not being able to spend time with their baby, or learn how to care for the baby and bond. Not only does this impact on the infant-father attachment but is likely to affect the father's self-efficacy beliefs in his ability as a father. Fathers felt they were unable to fulfil the fathering role at the time their baby was in the unit. This feeling was soon rectified upon returning home.

“What is the difference between caring for baby at home and caring for baby in the unit? How did it feel and in what way was it different?

Well when he was in here I didn't really have that much to do with him which was a wee bit upsetting for me because the whole point of having children is to look after them so it was a bit of a....it was quite enjoyable for a wee bit for him to come home and get back into sort of looking after him again.” (Participant 1)

The nurses becoming part of the network of carers for the baby contributed to the father's feeling left out. The nurses becoming involved in child care was a complex relationship. Generally fathers spoke of the nurses having limited involvement with their baby and appreciating the involvement. When nurses became involved it was to help the mother. As discussed before the fathers prioritise the mother-baby bond and want to be protective and caring of the mother. The father takes his cue from the mother regarding caregiving.

“...we would feed him and try and put him down but then he would start crying and (partner) would say just let the nurses look after him.

How did that feel when the nurses came in to look after him?

It was a bit difficult. Because you know you're the father you should be saying well he's my child my responsibility I don't want anyone strange looking after him. I wasn't obviously too pushy at that point because I knew it was kinda upsetting (partner) at that point that she wasn't coping well with the crying and whatnot. So

you kinda just have to take that wee bit of a back step and say well I'll just have to grin and bear it to an extent." (Participant 1)

The father is in a dilemma, does he exert his own desire to care for his infant and therefore diminish the importance of the mother-baby bond should he succeed in comforting his infant. Or, does he allow the nurses to care for the baby therefore preserving his relationship with his partner, the importance of the mother-baby bond, and the mother's trust the nurses are available to help when he is not, but miss out himself. This father decided to 'grin and bear it' concealing his needs to bond.

The negative consequences of feeling left out are that fathers can feel unskilled in the paternal role. Social learning theory (Herbert, 1988) explains how behaviours are learnt by being provided with opportunities to learn, perhaps through instruction or modelling, and social reinforcement of those new skills. When fathers are 'left out' they are not learning the skills needed to care, neither are they learning that the father role requires them to care for the baby. In instances where the mother can no longer stay in the unit yet is too unwell to return home the fathers can feel very anxious at having to care for the baby when they feel unskilled to do so.

"And then I had to obviously....the anxiety of basically being thrown in at the deep end. And I felt now I was solely responsible for (baby). Don't get me wrong I don't mean that in a selfish way because (baby) is my flesh and blood but ...erm ..I hadn't been doing ...everything. I hadn't been there for 7 weeks apart from going down 4 times a week and doing what I could. (Participant 2)

When mother is returning home with the baby, fathers who feel unskilled may be more reliant on the mother to be the primary care giver, which could potentially place greater strain on her.

5.1.1.5. Making time for siblings to bond

The fathers who had older children to care for did have an additional caring role to play within their family. Father's spoke about their belief, and their partner's belief, that it was important for the baby to bond with siblings.

"She obviously knows that it is important for (baby) to be with the rest of her family too." (Participant 5)

Fathers spoke of their older children's excitement at the new baby's arrival and the importance of the siblings having time together.

"At the time obviously I think my daughter felt a bit lonely or certainly was missing her mum and brother. There was a lot of hype prior to his birth you know. Your brothers coming blah blah blah. Then when he was here she was quite wanting to be involved with, you know, helping, watching. And then for all of it to just sort of stop when he came in here. I think it would maybe have been hard on her in that respect." (Participant 1)

"What makes me happy is the fact that when my youngest daughter sees my other two kids she... that really brightens her up, especially my daughter. (Baby) just loves seeing her big sister. She makes such a fuss of her. She really gets excited. So when I come in, we all come together, I am happy to see my wife and obviously I want to see my daughter but I know my daughter is so happy seeing my kids that that's fine. They can play with her. When we come down we have only got so many hours." (Participant 5)

Again considering ideas of cognitive appraisal and coping (Lazarus & Folkman, 1987) holding this belief within the family in a situation where family members are separated is likely to lead to a coping strategy which attempts to reunite them. Participant 5 clearly recognises the strong bond between his children and prioritises that over his own needs to see his baby. Although attachment theory focusses on the bond between infant and mother, the bonds between baby and older siblings will

likely be formed in the same way through the sibling responding consistently and sensitively to the infant's needs.

The second major category is:

5.1.2. KEEPING THE FAMILY TOGETHER

Strained relationships can cause additional burden on a family during a crisis (McCubbin & McCubbin, 1993). The families in the study were already in a time of transition incorporating a new member into the family. In addition, the experience of illness and separating the family through admission into the unit makes it a difficult time for family cohesion. Father's describe their experience and how they try to manage family relationships in the following categories.

5.1.2.1. Relationships under pressure

The mothers experiencing postnatal mental health difficulties affected the whole family. Admission to the unit alleviated some of the pressure on relationships as it provided hope of recovery. Although, when family members were separated for long periods, due to limited visiting, this added considerable relationship strain. Fathers spoke of the need to support the family unit and strengthen relationships.

"I guess if your wife or partner is in here it is because she has got a young child most likely, therefore it's a time where bonds and relationships are required to be reinforced and strengthened. Because they are under quite a lot of pressure. And you have got to keep that as strong as possible. I believe that by doing that then ...the

form of recovery, whatever happens after that will happen as best as it possibly can. Not focus on oh my goodness my wife's ill what do I do? Focus on, right keeping everyone else as solid as you can and supporting your wife as best you can..." (Participant 5)

During this experience in which fathers have limited control, the relationships are something fathers can influence. Further relationship strain between the parents is discussed in 'adjusting the couple relationship'. The relationship between older children and their mother was also disrupted when they were separated. The relationship between fathers and older children changed as they became primary caregivers for them and had to cope with their distress.

"The first four weeks in particular every night he cried. Things like that, as a father, when your wife, his mother is taken, when she is not in the environment he is used to, as in home. Dealing with that was quite hard." (Participant 2)

Furthermore, pressures on the family relationships can come from external agencies. It is not unusual for there to be child protection concerns when a mother has a severe postnatal illness. Any concerns are raised in the best interests of the child but it can cause considerable strain on relationships. One father was placed in the difficult position of choosing between his partner and his baby. However, the admission to the unit delayed this difficulty.

"I was basically put in the position where err it was either a choice between (partner) or the baby. Because the social work department were initially actually quite determined that they wouldn't allow the baby to be in the house with me and (partner)." (Participant 6)

During times of stress people are more likely to seek care from their attachment figure (Bowlby, 1988). In this situation the mother and father are likely to seek care

from each other; likewise the older children will seek care from their parents. When they are separated due to hospitalisation in order to cope alternative social support may need to be sought. For individuals with insecure attachment styles this is likely to be difficult.

5.1.2.2. Trying to be Normal

There was a sense that fathers were trying to retain a sense of normality within this unusual scenario. ‘Trying to be normal’ may have been a way of coping with feeling overwhelmed which will be discussed later. Furthermore, in the absence of guidance regarding new ways of behaving in a novel environment individuals are likely to behave in ways which are familiar to them. Fathers spoke of caring for the baby in the same way they would expect to at home.

“When I was here we would do things we would normally do. We would go and play or we would go out for a walk or whatever.” (Participant 3)

Staff members had little involvement in what the fathers were doing in the unit. For fathers who were comfortable with caregiving this freed them up to do what they would do normally, and created a relaxed atmosphere. It would also facilitate the transition home if fathers became accustomed to similar caregiving duties to at home

*“I am pretty much left to do as I please. If I want to be feeding the baby I can do that. Or if (partner) is resting I can take the baby and walk around the unit.”
(Participant 6)*

Fathers tried to retain normality for them and their partner as a couple. However, the arrival of their first children will change the couple into a new identity as a family. It felt like retaining normality as a couple was a way of strengthening their own relationship to support each other, but potentially some were struggling with their transition to being a family and were trying to retain their previous couple identity.

“I think they like you to do things together so you still have the bond between you and your wife. And the family bond as well. That’s quite important as well to keep that link between you and you wife. That takes away the reality of having two wee girls to look after as well when you are going up. When the two of you are going for a walk and leaving the girls... That wee bit of normality.” (Participant 4)

Retaining a sense of normality away from the unit was important in reassuring their other children.

“I needed a bit of time to get them organised but also let them two know that there is nothing wrong. You know they knew that their mother was sick in the hospital, so I wanted them to realise that I was home and the family was still ok and we would be down to visit their mum as soon as possible. They were fine, get their same routine going, one was at school, they had no problem with that.” (Participant 5)

Retaining normality within this crisis situation did appear to be an adaptive way of coping for all family members.

5.1.2.3. Relying on Support from Family and Friends

Fathers received the majority of their support from family and, to a lesser extent, friends. Having social support available and being able to access it is regarded as helpful in both the ‘resiliency model of family stress, adjustment and adaption’

(McCubbin & McCubbin, 1993) and the cognitive-relational theory of emotion and coping (Lazarus & Folkman, 1987). The intensity of the support varied but several participants were receiving intensive daily help from family members, on occasions even moving in with them. Fathers received practical and emotional support.

“I probably wouldn’t be sitting here today if it wasn’t for my mother in law.”
(Participant 2)

Several fathers experienced a great deal of stress and acknowledged they would not have been able to cope without support. Some fathers did not feel the need to rely on friends or family as much. However, the father’s attachment style will impact on the quality of his network and how readily he will turn to others for support and communicate his needs (Stuart & Robertson, 2003). It was clear that some fathers did not have a wide support network, or were unable to access support due to their partner’s fears of stigma.

“My wife has always been very reluctant to let friends know that she suffers from mental health problems. I think only one or 2 really close friends know what she’s been suffering from. And they might not have even realised she was in here immediately after baby was born.” (Participant 3)

Being ‘unable to tell’ gave some fathers added pressures, as friends would contact them with well-meaning messages or they would be unable to ask for time off work. One father acknowledged he had been lucky to have a good support system, and felt the unit should be aware other fathers may need extra help and provide it.

“...it sounds like your own support network has been very helpful for you?

I’ve been very lucky in that respect. Because I don’t suppose everyone will have that which is maybe why I think the support from the unit for the father could be a wee bit better. Just to sort of...because not everyone is gonna have the friends or support that maybe I’ve got.” (Participant 1)

The father’s attachment style will affect his ability to gain support from the staff in the same way it affects his interactions with other people in his network. Securely attached fathers will ask effectively for support and their internal working models will suggest to them support will be provided. Fathers with anxious ambivalent attachment styles are likely seek their own reassurance and care but may appear to struggle to provide care for others. Finally, fathers with anxious avoidant styles lack the belief that their needs will be cared for, so may avoid interaction and appear self-reliant (Stuart & Robertson, 2003).

5.1.2.4. Adjusting the couple relationship

A loved one experiencing a severe illness is a time of crisis for a family. When the mother experiences a severe postnatal mental illness for the first time it can be very shocking for the father particularly when the mother experiences changes in her personality.

“She was totally not good, emotionally, and her personality was ...she wasn’t the same happy wife I had left.” (Participant 5)

It can be difficult for the father to understand, particularly when he does not have knowledge about the illness or likely recovery. The experience of illness can affect the security the father feels about their relationship.

“It is quite easy I am sure to think oh my goodness this is the end of our relationship because it’s not an illness where she is sick and she needs this medicine and she will be better after x weeks, you know.” (Participant 5)

Furthermore, the couple being separated has an effect on them both. As discussed earlier individuals are likely to turn to their attachment figure for support in times of crisis, and this may be their partner. When the father misses the mother it influences how he wants to spend his time at the unit.

“We just see each other on a Friday, so it is almost instinctively really we want to spend time (together) really, because we miss each other all that while.” (Participant 7)

All fathers spoke of having time with their partner, and the majority of fathers tried to have a small proportion of their visiting time alone together. Father’s felt they were supported in this by staff offering to care for their baby.

“...on occasion, say for arguments sake, (partner) would have to say to staff “look, we are just going out a wee walk”. Say we were going in the hospital grounds or up to the canteen. “Oh aye that’s fine, how long will you be?” 20 minutes, half an hour. (...) “(Baby) will be fine, we’ll put her in the nursery”. It was almost like they were encouraging us to have a bit of time together.” (Participant 2)

There was a sense that fathers had to be protective of their wife, the protective role was important in the wife’s recovery. Participant 4 described his role as:

“Keeping her alive. Giving a reason to live. Coz she didnae.” (Participant 4)

More commonly fathers spoke of advocating for their partner and being someone their partner felt dependent on. The father's protective role seemed to be desired by the mothers and when this was done well it seemed to strengthen the relationship.

“Erm she did say a few really nice things to me like I was the only one that was keeping her from doing things to herself. Or, you know she let me know that she was completely dependent on me. She would come to me for anything over anybody else.” (Participant 4)

However, when fathers did not take the protective role the mother desired it could strain their relationship. Participant 7 describes a scenario where his partner wanted to go out on pass from the unit and staff were asking whether she was well enough to manage.

““It’s you (mother) who needs to tell them that ‘look I am fine’. I can say stuff on your behalf so it doesn’t look like I am pressuring you to say anything. If you feel you are ‘ok’ say to them right now I feel ok”. “Oh no I can’t cope” and she went out the room. And then after they left I am like “why didn’t you tell them”. So we got into this row because I was upset that she wasn’t able to stand up for herself. And she was upset because she thought I should have stood up for her.” (Participant 7)

When the mothers are unwell they are likely to be more reliant on other people to support them. This heavy reliance on the father could potentially both strengthen and strain their relationship. Disharmony between the couple or between the father and staff appears to occur when they have different goals and have appraised the situation differently, so the coping strategy the father implements is out of sync with expectations of the mother or staff member. For one participant who was unable to visit frequently he was aware that people may have expected him to be more caring and protective of his wife but he felt she was being appropriately cared for, and

because his family was larger he had other childcare responsibilities.

“From my point of view, from my experience because I have got 2 older kids. That’s what I focus on. And some people might say I should have focussed more on my wife and my younger child but my thought was any form of abandoning those two older ones...I thought as much as anything they need me more now that what my wife does. Although my wife needs me she she she, her getting better in the early stage of it was more to do with getting her down here, getting her medication, getting her support and almost getting her away.” (Participant 5)

Communication between couples was often reported as not optimal during the partner’s illness. When fathers were relying on their partners in order to understand her illness they were sometimes left with the impression she was doing better than she was, as she would try to appear well. It may be hard for mothers to be open about negative thoughts they have experienced due to their illness. If the father is relying on her for information it can be hard to get a clear picture, and sometimes the father has to gather information from a range of sources.

“...I’ve since found out (partner) hasn’t told me everything when she has been here, as to how she is, and how she is feeling and everything. Erm how her rehabilitation is getting on...I have been led to believe by (partner) she is getting on better than she really is. And I get here and find out she has not been quite so good, you know. Erm but that’s more down to...just (partner) not lying at all, just she doesn’t tell me things. But then again I suppose that’s the nature of her illness. She doesn’t want to tell me anything because she doesn’t want to worry me, or get the kids upset and stuff like that, that’s what the nurses say to me so. So often I will go to the nurses, I will speak to any of the nurses that are available, they’ll fill me it”. (Participant 5)

Before staff can share detailed information with the father about their partner’s condition they will ask the mother’s permission. In the majority of cases the mothers allow information to be shared. If she refuses they are bound by confidentiality rules so they will only be able to give fathers a very basic outline, unless there are issues

which pose a risk to the mother or other people. Passes out of the unit may be restricted if the father, who will be responsible for the mother, cannot be fully informed. The mother may on occasion be asked to share information with the father.

“I was told that there was something that my wife should discuss with me that they didn’t want to discuss, but they felt that she should actually be the one that told me. So in actual fact she didn’t actually specifically tell me on that date she was being discharged, or when she was in the perinatal unit, she told me a wee while later. You know, it was on that day though.

I wonder if it was a struggle for her?

No, well well she did say that, she did say to me, she did basically say to them as well as to me, that prior to that she didn’t really want to tell me because she felt guilty about it.” (Participant 8)

Regarding the resiliency model of family stress, adjustment and adaption (McCubbin & McCubbin, 1993) if the fathers are without the full information on their partner’s health the fathers may not display a good adaptive response to the difficulty. Without clear information they may not appraise the situation adequately or access appropriate support.

The next major category is:

5.1.3. FEELING CONTAINED

The admission to the unit relieved fathers of worry they felt due to their partner’s illness. They felt contained and supported by the unit caring for their partner, it helped the father manage. The following categories explore this further.

5.1.3.1. Relief of admission holding care

All fathers experienced a period of uncertainty and worry when their partners had been experiencing symptoms but they had not yet received specialist help. Fathers felt a sense of relief when their partners were referred into the unit.

“I think at the time probably what I would...my overriding kind of emotion would have been relief that finally she was in a place where people understood what was going on.” (Participant 3)

Considering the cognitive-relational theory of emotion and coping (Lazarus & Folkman, 1987) the admission to the unit changes the situation the family is in, it reduces the demands on the father in terms of managing her illness which he may have felt helpless to influence. It allows fresh appraisals and new coping mechanisms to be applied. The admission made the fathers feel better and provided hope of recovery.

“Overall I thought the experience was very good. It certainly did the mother the world of good. It has also made me feel better because that whole point, everything was quite, very upsetting and everything and obviously when she got to that unit she was finally receiving the help she was needing then as she got better it made everyone else, well it made me feel better in myself because then I could see things moving forward rather than things getting stuck and going backwards.” (Participant 1)

Prior to the admission fathers were shouldering much of their partner's difficulties. Having the help of professionals they could see their partner could trust relieved some of the father's stress.

“I could see that she was able to talk to them, tell them about her problems and that. So that was good. It took a bit of the weight off of my shoulders.” (Participant 4)

Fathers described feeling helped by the unit and this was due to the admission holding the care of their partner and also due to the expertise of the unit, described next. The unit appeared to reduce the severity of the ‘crisis’ experienced and therefore helped the father to manage himself and become more available to manage other difficulties.

5.1.3.2. Appreciating expertise

Fathers were appreciative of the specialism of the unit, and felt it was better than services they could have received in the community which didn’t have a mother and baby specialism. They were reassured by knowing staff were knowledgeable about the difficulties their partner was experiencing. The specialist service also meant that their partner and baby could remain together which, as discussed earlier, was very important for the fathers, and facilitated the infant-mother attachment relationship

“So it has been helpful in that sense, A) to put her here and know that she is being taken care of, (baby)’s being taken care of and erm you know everything is a well-managed environment with professionals, so it puts my heart at rest, my mind at rest.” (Participant 7)

“I think probably we were actually both really appreciative of everything in the unit. I think we felt it was much better than anything in the community or anything else that we had heard of elsewhere. I think we were very impressed indeed.” (Participant 3)

Many fathers mentioned there are only two units in Scotland and although they were appreciative of getting a place those who had to travel long distances wished for

more local services. A lot of trust was placed in the staff that they would make their partner better as they had the knowledge and skills.

“Here I am trying to support her and say the right things to her but to make her better is hopefully down to the staff here. Obviously she needs to do things to make her feel better herself but they are the ones with the expertise.” (Participant 5)

This also reflects the fathers may have a poor self-efficacy (Bandura, 1977b) about their own abilities to help their partner, which may have developed when they struggled to manage her illness before admission. This is echoed in their anxiety on discharge and lack of involvement in the treatment plan. Clearly the staff were experts and have training in mental health which the fathers do not. Fathers felt very contained by the staff members’ expertise.

5.1.3.3. Welcoming but not quite home

The fathers described the unit as different to other hospital environments. Care institutions can be considered as an attachment figure for patients (Adshead, 1998). For several fathers the unit was a containing environment for the family and reduced anxiety, it therefore became a secure base. A secure base can be a safe environment for recovery (Adshead, 1998). During the feedback session a participant commented he felt reassured that he knew the unit would be there to return to if needed. Fathers said there was something more calming about the unit than other hospitals but there was still a clear sense it wasn’t as comfortable as home and that there were restrictions on where you could go. The family room helped the families to be together and added to their sense of normality.

“Within the unit there is a family room which most of the time we had access to. Albeit it was a room that, trivial as it may sound but it had toys etc. which was good for (son). And a comfy sofa, and it just, it sounds trivial but, it did actually, a room like that, it did actually help us as a family to be together in the same room rather than to be in (partner’s) bedroom.” (Participant 2)

“It is quite a nice experience. It’s just a bit, you feel a wee bit (...) you can’t fully relax because you are still in a hospital environment not at home.” (Participant 1)

Although the layout and décor of the unit was important it was staff that were most influential in creating the atmosphere. The fathers’ experiences of the unit changed over time, particularly when he got to know the staff, or when staff became less concerned about his partner’s illness so could reduce their vigilance of her.

“Probably (what) made things easier for me... erm I think it is a change in the atmosphere actually. Maybe repeating myself a bit but to some extent the behaviour and attitude of staff being more welcoming I guess. And probably no longer seeing my wife as this kind of acutely ill patient who had to be their priority. I think there was a change, probably the second visit after (baby) was born. Towards the end of that time but certainly on subsequent ones there was a change there that made things easier for me because I no longer had the sense I was stepping on their toes.” (Participant 3)

Being able to incorporate these changes over time into his cognitive appraisal of the situation, and adapt his coping strategies accordingly will assist the father to cope optimally within the environment (Lazarus & Folkman, 1987). Participant 3 expressed a sense he was in somebody else’s territory and he didn’t want to ‘step on their toes’ by doing things within the unit and getting in their way. The ward being a locked mental health ward and the surveillance that is associated with the patient group also impacted on the fathers experience and will be discussed in ‘feeling watched’.

5.1.3.4. Mixed emotions on discharge

When the partner and baby are discharged there is a transition where they are incorporated back into the family unit. It alters the demands on the father and he again has to adapt his coping methods. Fathers expressed mixed emotions on discharge. There were happy to be having their partner and child home as this was a return to normality and delayed expectations of family life. However, they also felt anxious about how she may manage her illness at home.

“...the overriding feeling would have been very happy to have them home it’s much better to have people at home than in hospital. The first time, slightly anxious about how things would go. Because although (partner) was less anxious and more rested she was still suffering from a lot of the same symptoms she had previously.” (Participant 3)

Upon discharge fathers were no longer feeling contained by the unit and some fathers felt the responsibility for caring for the mother would be transferred from the staff to them.

“...regarding my wife getting better erm I feel I will be more important when she is actually out of here.” (Participant 5)

They felt unprepared to take on the caring responsibility at home as the unit had not been involved in making any changes there, so the father felt that was something he would have to organise himself.

“...they didn’t really have any involvement with the home life or anything like that so that still all needed to get sorted out and arranged.” (Participant 1)

Some fathers felt strongly they will be the main carer, the front line, and they needed

to be more involved in her care in order to support her discharge.

“...when it comes down to it the father in that sort of circumstance is the front line troops. They are the front line. They are having to deal with matters on a daily basis. Therefore their involvement is absolutely vital. Because when a mother gets discharged, they are going home, and the only person that’s there to support them potentially is the father. Therefore their role must be regarded as absolutely key right from the start.” (Participant 8)

Their self-efficacy about their abilities as a caregiver for their partner was low, but they had a desire to be involved. Potentially their abilities and self-efficacy could be improved through involving the father in care-giving, educating him, modelling appropriate support, and reinforcing successes within the unit prior to discharge.

The next major category is:

5.1.4. FEELING OVERWHELMED

The experience of their partner suffering from a postnatal illness was difficult, although the admission to the unit reduced stress it introduced additional stresses. The accumulation of stresses and demands on the father during this time could lead to the fathers feeling overwhelmed. When fathers were unable to cope and manage for themselves it will make them less likely to be able to support other family members. The following categories illustrate ‘feeling overwhelmed’.

5.1.4.1. Experiencing anxiety and stress

All fathers discussed anxiety and worry they experienced due to their partner's illness. Distress was particularly strong if this was their first experience of mental health difficulties, or if their partner's condition had deteriorated.

"I was really scared. I was quite upset. Because I didn't know what was going to happen." (Participant 4)

The uncertainty of the situation was particularly anxiety provoking. Fathers searched for signs of recovery and reassured themselves their partner would improve as a way of coping with the distress of her illness.

"I think if you live with someone who's suffering with something like that you have got to keep saying to yourself they are going to get better and you're always on the lookout for signs it's getting better. Otherwise it would be terribly bleak." (Participant 3)

For two of the fathers their level of anxiety reached a severe level resulting in them experiencing similar negative thoughts to their partner.

"It was really scary, especially I think going home at night and things. Like just lying awake and then, I dunno, obviously I hadn't been sleeping well as well so the thoughts that (partner) was speaking to the psychologist I was getting the same kind of thoughts. Not wanting to kill myself but just that I couldn't concentrate on anything. I couldn't relax because my mind was just racing, just situation after situation, what's going on." (Participant 4)

A high level of anxiety usually debilitates an individual's coping abilities (Bandura, 1977b) so the father is unlikely to be able to care for their partner and child efficiently when anxious. The father's anxieties were not only about the mother's

health but also the impact on the wider family, they were aware that situations which were causing them anxiety were likely to be causing the rest of the family stress.

Participant 2 describes a situation in the unit where his partner's condition had deteriorated.

"Erm I think it must have been one of the worst days of my life. If I am being honest. And anxiety. I think it's probably just as well I was in the hospital because at least if anything goes wrong you know..."

You felt you were in the right place!

I felt at least I'm in the right place. And I did actually laugh to myself. I thought at least I can still laugh about it. Although joking aside, it was just horrendous. Not only on me, on (son), on (partner)'s mum and dad, the family." (Participant 2)

Individuals experience anxiety and stress when they appraise a situation as threatening to their own or their loved-ones well-being, the intensity of their emotional reaction will depend on their coping mechanisms and personality factors (Lazarus & Folkman, 1987). The anxiety and stress fathers spoke about was highest before admission to the unit as they were reassured by the unit holding the care of their partner. Additionally, when fathers were confident their partner was managing her illness and they felt admission to the unit was for a short assessment they were less anxious. One father appeared to experience minimal levels of stress. In this case the admission to the unit was a preferable option for the family as he had discussed there would be intensive social work involvement otherwise. Potentially his stress had been minimised as the unit was the most preferred treatment plan. His stress centred on issues relating to travel.

"I wouldn't say I felt stress. I was happy with the unit and (partner) is being well looked after. So, erm the only stress is (the drive)." (Participant 6)

These small daily hassles can accumulate. Daily hassles have been found to be a greater predictor of psychological symptoms than life events (Lazarus & Folkman, 1987).

5.1.4.2. Feeling Watched

The mother and baby unit provides care during an episode of severe postnatal mental illness, or for assessment as the mother is at risk. There is a level of observation that the staff have to do. Fathers were aware of the need for surveillance of the patients within the unit but felt this affected the atmosphere.

“How would you describe the atmosphere in the unit?”

Erm quite intimidating at first to be honest. Because it's a mental health unit and there are certain precautions you have to take. It's quite a high ratio of staff to patients so... I think when I first went in, I have never spent any time at all in hospital as an inpatient so I have nothing to compare it to, but when I first went in I was quite struck by how intense the scrutiny was of the patients compared to a normal hospital ward.” (Participant 3)

They felt this improved with time and familiarity and that some staff members were skilled in balancing surveillance with being friendly.

“Once they know you they speak to you by name and they are not intrusive. They take a step back. Even though (partner) is, at certain times while she has been here she has been under observation. So therefore they have to combine that observation with giving the family space to visit her. And they have done that really well to be fair.” (Participant 5)

Fathers are also observed by the staff to assess whether they will be able to care for their partner and child if they were to go out on pass from the unit, or be discharged.

Dependent on the circumstances this is not something which always discussed with the fathers. Fathers noticed this and had a sense of being watched, but they were unsure if they were actually being assessed. For some father's this made them feel uncomfortable, others were expecting it to happen but it had not been formalised with them.

"I almost felt "are the staff watching me?" albeit that it is quite informal with plain clothes on etc but ...erm ..that's how I felt at times "are they watching me? Are they watching the family?" (Participant 2)

"I don't know whether they are actually assessing me as well. I assume they are making some sort of assessment of father's ability to actually participate." (Participant 6)

This undisclosed surveillance of the fathers could affect father's relationship with the staff and also their potential to learn child caring skills from knowledgeable professionals.

"...I think there was always a slightly awkward relationship with the nursery nurses who always know best what to do with your baby. First week with a new baby you have no idea how to do anything. But there is always this sense of being watched every time you try to fill a bottle, change a nappy or something." (Participant 3)

For fathers who have low self-efficacy in their abilities to provide care, feeling watched may make them feel anxious. In order to reduce anxiety they could potentially become avoidant, which would hinder the development of effective coping skills (Bandura, 1977b).

5.1.4.3. Life turned upside down

Having their partner and child admitted into the unit caused varying levels of upheaval. This was mainly influenced by how far away they lived from the unit and length of admission. Some fathers had to move in with relatives to be able to visit frequently but also to get the level of emotional support they needed at this difficult time particularly when their partner, who may naturally be their main source of support, was unwell.

“Erm it felt in some ways our life had almost been turned upside down again. The fact that I was living with (son) in a different environment down in (City) and having to travel to (Unit).” (Participant 2)

“Then I started staying with friends (nearer Unit). My pals mum and dad, my aunt, and staying with my uncle. I very rarely went home for 3 months. Just to get clothes and stuff.

Why was that?

Because home to (Unit) is an hour drive. And going home at night and getting up at 6 in the morning.

Ah ha, so it’s really the time?

Aye time and the stress as well. I wasnae wanting to be alone because it wasnae really great when I was on my own. My mind started to race.

I was wondering if that was maybe why you had stayed at friends.

It was better to be with folk. Folk you could trust and talk to and things like that as well.” (Participant 4)

One father who lived extremely far away and had two older children to support, took the decision to limit the level of upheaval his family experienced. He tried to retain normality for them and separated the parenting role so that he would care for the older children whilst his baby and partner were cared for by the unit. All fathers experienced some changes to their lifestyle, even during short admissions they had a more hectic lifestyle, greater demands on them, and less time to do essential tasks.

“Well the down side of it is it has taken me out of the house all day pretty well plus the travelling time. So if there are things I have to do, like insurers, they have to be done 8pm on the computer (...)

It sounds a very busy time?

Yer it's all squeezing things in. It's like today (...) I had to go to the bank and then back to the house to get my bag and then hit the road. I just need to keep pushing tasks and chores into the morning and late evening.” (Participant 6)

This hectic lifestyle appears to distract fathers from their experience; this could be protective but could also prevent them processing the emotional aspect of the experience.

“It wasn't as though I was upset or anything. I can't say I had a huge amount of time to think about it because you know, at work, and then it was rush home, and get the daughter sorted out and get her all organised, and then zooming off. Life was at 100 miles an hour.” (Participant 1)

5.1.4.4. Travel and work pressures

Work and travel impacted on the frequency of visits. All fathers were in employment and several felt being the breadwinner for the family was one of their primary roles. When mothers and babies were admitted in the early stages many fathers were able to take paternity leave and additional leave from work so they were able to spend a larger proportion of their time visiting. However, for longer admissions and admissions when the infant was older fathers were more restricted in their flexibility. If fathers were not on leave their visiting time was generally restricted to after work or weekends. The unit does not have restricted visiting hours. Many fathers had professional occupations which gave greater flexibility in terms of

managing their time and working from home, which freed them for visiting. Despite this the time commitments of visiting and traveling were still a burden for some that they were relieved to end on discharge.

“I come on Mondays and I come on Fridays and erm that’s just due to the nature of my job really er I can’t come any more often than that. And erm that’s just what works out basically because Mondays, normally Mondays I work from home. So my time on Mondays has been flexible...” (Participant 7)

The unit provides a service for health boards across Scotland and some of the distances travelled can be considerable. Whether fathers were travelling after work or not, the distance travelled had an effect on many fathers and restricted how often they were able to see their partner and child. The amount of time visiting could easily affect how supported the mother feels by her partner and how well the father is able to bond with his child. For some individuals work was also a coping strategy which helped distract them from worries and concerns.

“What’s been helping you manage, it sounds like work?”

That’s it really, it’s work. It’s work, it’s work, normal day time work and then night time work which is my work. My company. I think that is it.” (Participant 7)

How a father appraises these daily hassles will impact on his chosen coping strategies, and resulting emotional experience (Lazarus & Folkman, 1987). Fathers’ appraisals of having to travel and work seemed to vary over the admission between a threat to time with their family, or a challenge that they needed to meet all demands.

The next category is:

5.1.5. EXPERIENCING AND MANAGING UNCERTAINTY

The fathers experienced uncertainties over the course of their partner's illness. McCubbin and McCubbin (1993) recognised ambiguity about a family member's diagnosis and the course of their illness and treatment created additional hardship on families trying to deal with a crisis. These categories capture uncertainties experienced and how fathers attempted to cope in order to manage the situation for themselves and their family.

5.1.5.1. Taking each day as it comes

Fathers spoke about 'taking each day as it comes'. This was a solitary way of coping which helped fathers manage day-to-day tasks and the uncertainties of their partner's illness. The first time 'taking each day as it comes' was introduced was when a father was describing how he coped when his partner was discharged.

(Talking about the return home) **"So it sounds like you had to adapt?"**

Well there was a wee bit of adaption but we managed, and things are getting better all the time.

Did you have any guidance in that sort of adaption phase?

Not really no

How did you work out what was best?

Wing it!

Wing it! Just have a go?

For lack of a better word. Take each day as it comes and just see how the situations are going." (Participant 1)

One father felt staff had encouraged him to 'take each day as it comes' by advising him his partner would have both good and bad days in terms of her illness. The postnatal mental health conditions these mothers experienced can fluctuate rapidly,

particularly puerperal psychosis. So by offering this advice the staff may be preparing the fathers for the uncertainty they may face.

“Erm one thing I was aware of and which staff were keen to tell me was that there would be good days and bad days. So in that sense taking each day as it comes was quite a useful way to deal with the situation. That there would be ups and downs and that probably actually kind of setting a long term goal of my wife getting better or being able to do something by a certain time probably wasn’t actually very helpful. Things would improve or deteriorate (...) anything that might upset her would be a setback. Erm I think taking each day as it comes is probably...was probably good advice. It probably helped me to think that this was a long term thing that we would have to live with.” (Participant 3)

Taking each day as it comes also encompasses the upheaval the family is dealing with and the solitary father plodding on with the demands of daily life. By just focussing on each day he can manage all he has to do, and remain available for his partner and baby. By creating a routine to the visiting pattern calmness and stability develops.

“It just becomes a way of life. That is your life. You go to work, you go to the hospital, see your kids, you go home and sleep. And do it again the same day. It’s just one day at a time. You have no plans. You can’t think ahead or anything because it is only that day that matters. Life just stops.” (Participant 4)

Fathers tried to keep up all their daily demands with the addition of visiting their family in hospital. Without being able to reduce any demands there was little they could do to manage.

“How did you manage?”

I just slept a lot less. I mean I always think you do what you have to do.” (Participant 3)

Fathers felt it was their duty to cope with the daily difficulties they experienced during the admission. Perhaps this is related to the protective role some fathers discussed, as a protector the father may need to appear competent and manage on his own.

“Sometimes you have to take what life throws at you.” (Participant 2)

5.1.5.2. Understanding illness

The fathers did not express a clear understanding of their partner’s illness. They were uncertain of her diagnosis, precipitating or maintaining factors. Although many fathers did discuss previous stresses their partner experienced, and past mental health difficulties, the link between those experiences and the presenting problem was not always clearly expressed. The father’s understanding did not appear to be affected by the length of admission but may be a result of how fluently they could establish communication with the unit staff.

“What has she been diagnosed with?”

I I I think she, I think it’s, I think it’s, to my knowledge it has been confirmed. But I’m led to believe, at least they believe its erm psy-chotic depression. Psychotic depression. Erm.. it’s hard to know exactly what triggered it.” (Participant 2)

“...for the last 3 months the diagnosis has been a bit...well it was only at that meeting with social work in February where the consultant said catatonic schizophrenia.

Was that the first time you had heard?

Well I have seen that and I have seen bi-polar disorder and I have seen depression and somebody had mentioned like a reaction to some sort of trauma.

So a whole range?

Well yes... But I didn't get that diagnosis until quite late. So rather frustrating. So I am quite keen to hear from the consultant here, based on their observations, what their views are.

(Participant 6)

For many fathers this was their first experience of a family member having mental health difficulties and they didn't have much knowledge to draw on.

“The only thing I had heard of was postnatal depression but I didn't realise it would be like this. I just thought it was you would be quite grumpy. I didn't really know anything about it.” (Participant 4)

Similar to Webster's (2002) findings that couples desired more information about postnatal depression, these fathers wanted more information. As time went on, if fathers were able to establish communication with the staff their knowledge of the illness grew.

“Obviously I knew very little at the start but then as things went on (staff) were telling me things about what it's like.” (Participant 4)

A small number of fathers did not seem to understand the serious nature of their partner's difficulties. This was noticed by the researcher during interviews. With no previous knowledge of the mothers the researcher was left feeling confused as to why they had such a long admission. The father expressed his own confusion

through describing an incident where the staff were clearly concerned about his partner yet he felt there was nothing to worry about.

“There is no emergency about it. ‘Oh she is having an emotional breakdown’ let’s drive her back! In an hour 2 hours we are back. So why would she say she can’t go? I just don’t understand that. Because they have not got a specialist unit there is no reason to say she can’t go. I I I can’t understand that. Because there is not an emergency about the situation, what is the worst that could happen (...) we are not advising for (partner) to go ‘cause we think she can’t cope. Well (partner) is saying she can cope, she is looking all bright and jolly, we have had a lovely weekend so far why are you saying she can’t cope?” (Participant 7)

The father’s appraisal of the situation and resulting coping mechanism may not have been appropriate due to insufficient information. The fathers are put in a position of trust by the staff when mothers and babies are released on pass. The staff need to rely on the father to be able to notice and respond to difficulties. If there are concerns about the father’s abilities to understand the illness and respond appropriately it can be more difficult to release the mother for pass and discharge.

Participant 8 also wasn’t concerned by his partner’s admission. His prior knowledge of mental health and the belief postnatal depression is a common illness may have added to his relaxed attitude. It is with hindsight he wishes he had found out more about her situation.

“I didn’t think what was happening was strangely enough that concerning. Because, I mean, you hear about how often women experience postnatal depression and other things anyway. Erm and it’s a relatively common occurrence and so if you are in that circumstance, if you are like me anyway, erm you are not immediately thinking oh dear this is horrific! You are thinking oh this is perfectly understandable, perfectly normal, erm lets just get on with things. Try and see some improvement here. Do the necessary steps to improve certainly my wife’s situation and you know I really wasn’t that concerned about it at all. Erm obviously that wasn’t the attitude that was held by other people, but my concerns at the time were definitely for the way my wife was feeling.” (Participant 8)

What attributed to their lack of understanding appeared to be communication difficulties with the staff, which was affected by the fathers attachment style, personality factors, anxiety and also their own partner giving them the impression they were better than they were.

5.1.5.3. Understanding treatment

Although fathers felt their partner was in the appropriate place and was receiving help most fathers were uncertain about her assessment and individual treatment plan. The most knowledgeable fathers were again those who established good communication with staff. The introductory visit to the unit was appreciated and had been helpful to educate the family about the unit. Nevertheless, some fathers had very little knowledge of the treatment plan. They did not feel included in their partner's care and they felt this relegated them to having the status of a visitor rather than the next of kin.

"...nobody had ever really explained to me I don't think the real purpose of her being in the unit. I don't think anybody ever really sat me down and said, you know, "this is what we are hoping to do. Not just to keep your wife and daughter together" Erm it felt a bit strange at times. It almost felt like you were going down to visit somebody in hospital." (Participant 2)

"I had no idea about what was happening with my wife, who was assessing her, what sort of treatment was being suggested. The only person I was getting that information from was my wife. And of course I am assuming that if I am getting that information from my wife it's accurate." (Participant 8)

This illustrates the importance of conveying essential information to fathers because, as discussed earlier the mother is not necessarily able to discuss sensitive information with the father whilst she is struggling with her illness.

All fathers expressed uncertainty about the duration of admission, commonly underestimating it. Depending on the seriousness of a mother's illness and her response to treatment her recovery can be unpredictable. Therefore the duration of the admission can vary greatly. Families in this study experienced admissions of up to 5 months.

"I think when (partner) first went to the mother and baby unit she thought she was only going to be there maybe 2 weeks at the most. Erm we seemed to be under the impression she was only going to be there 2 weeks." (Participant 2)

Participant 2 experienced a 7 week admission. A long admission was difficult for the family as it reflected illness severity. Additionally, it increased demands on the father in terms of work (and leave) and prolonged the stresses of travelling.

Fathers were most knowledgeable about drug treatments. This is an important part of the mothers treatment and something the father may take a role in monitoring on discharge. However, the fathers did not express knowledge of whether their partner was receiving psychological interventions, or changes they could make to facilitate their recovery.

“Because at the end of the day it is her medication they are trying to get balanced and get right. Initially she was on this medication where they increase it gradually and the doctor was saying when you get to (dosage) she will be a lot more balanced at that stage (...) She has not had any adverse reaction so hopefully next month they will finish up with that and she can then come home. I would be happy that everything is all sorted.” (Participant 7)

One father felt his partner’s desire for him to help her in consultations resulted in him being knowledgeable. If an individual believes a situation exceeds their ability to manage they will avoid becoming involved (Bandura, 1977b). If fathers are encouraged both by staff and partners to become involved in aspects of care, their knowledge and belief in their abilities increases. Therefore, improved communication about the mother’s treatment and involving the father more could empower him to become more involved and make adjustments to his behaviour to facilitate the mother’s recovery.

5.1.5.4. Communicating with staff

All fathers felt communication with staff could be improved. Some fathers were skilled communicators who were able to seek out support and information. Other fathers were more uncomfortable in this role and wouldn’t naturally seek interaction with staff. Although many fathers commented that staff were always available it was only the more socially confident fathers who utilised opportunities to speak with staff. Some fathers who would normally be confident at communicating found they did not speak out in the unit environment.

The fathers who got the most detailed information and guidance acknowledged that their personality and experience facilitated their communication with staff but they had to put effort in in order to get guidance.

“I’m used to dealing with professionals and you know I speak to people for a living in a sense... so I always appreciated the more frank full explanations that I could get.

It sounds like you got quite good factual discussions with people

Yes

You got a lot of information. Do you feel you sought out people to talk to?

I think so yes. I think I did. I think sometimes you had to ask a couple of times. You had to convince people that actually you really did want to know what was going on. And you did understand what they were saying to you. But I think you find that when you are talking to doctors anyway.” (Participant 3)

Fathers who have a lot of experience communicating with professionals are likely to have higher self-efficacy in their ability, so are therefore more likely to initiate and manage communication. It is also important to consider the fathers own attachment style to understand the difference between those who established successful communication and those who did not. The father’s attachment style will be activated in times of stress (Bowlby, 1988) and will affect the formation of relationships with staff. Individuals with anxious avoidant attachment are least likely to initiate communication (Stuart & Robertson, 2003). The skilled communicators recognised they could easily not have engaged in communication. Fathers who did not initiate contact felt communication with staff members was very limited, to the extent they felt ignored.

“As far as my own experience was, I would go in and out the unit it would be rare that anybody would want to speak to me about things.” (Participant 8)

"I sometimes actually have to just say 'Hello' basically to make them acknowledge I am actually here. This is me saying hello. At least you respond. But then if I didn't say hello, well it has happened a few times someone will just walk in and walk out really. Walk in, talk to (partner) and walk out, without nothing to me. No no nothing. They are talking to (partner) about something to do with her health or do with the baby and I am just totally ignored and I just feel like that ...it's just not nice."
(Participant 7)

The unit is designed to support the health and attachment of the mother and baby and they are clearly the priority. This was also the priority for the fathers. However, fathers felt excluded from communication regarding the family unit because of this. They did desire to be included.

"...in as much as (partner) is the patient it kind of feels like, you know, she is the patient so we don't really care about you sort of thing. But in as much as she is the patient they should realise she has got a partner, that's her husband, he is father of the baby, and whatever it is you are doing you need to get him involved basically."
(Participant 7)

The mother and baby being the priority of the service means there are not commissioned services the staff can offer fathers. Some fathers said staff enquired about their well-being but had nothing to offer in support except recommendations they stayed with friends or looked after their own mental health. Several participants felt staff were not concerned with their well-being, but would like time to speak with staff.

"Did anyone ever come and ask about how you were getting on?"

No. er not to my knowledge no.

Nothing you can remember about someone enquiring about any help that you might need?

No.

Did you feel that there were some needs that weren't met?

Communication for a start. Erm..even an interview like this to some extent in the early days. Or just some..even..I don't know just occasionally a nurse sitting down

with me or somebody saying like “this is how (partner) is getting on. Or, how are you coping yourself?” I don’t know how things go on behind the scenes but yer I just felt erm I just felt lack of communication I think.” (Participant 2)

Fathers having a limited presence in the unit would affect communication. Fathers struggled to communicate effectively with staff within the unit environment. Some were aware they didn’t communicate much but struggled to understand what was preventing them. Half the participants discussed restricting communication and this seemed to be about not wanting to impose on staff or them to think badly of them.

“I do phone yer. Maybe not as much as I should. Maybe that’s the thing, (...) Maybe I should have phoned more often but again I think to myself if I phone more often they will think there’s so and so on the phone again, you know!! I don’t want to put myself, and I don’t want to put the doctors in a way they will think that of me. Which means I am probably less likely to get the best information.” (Participant 5)

If they appraise communicating with staff as a risk to their self-esteem then they are more likely to avoid it. There was a clear need for a lot of complicated information to be exchanged which would ease the uncertainties experienced. Fathers were not aware of what they needed to know, they felt if there were difficulties the staff would have told them, so when staff weren’t communicating with them they did not seek information.

“Did you ever feel like you had to seek out information from them?”

Er that’s a good question erm the simple answer is no because er again I had no reason to. I wasn’t told that there was any specific problems.” (Participant 8)

Either at the time or in hindsight all fathers thought they should have been more included and told more.

“There could be a bit more communication in general at times. Just maybe about (partners) progress or even lack of progress, I don’t know. It was kinda, I felt as as the father I could have just done with a bit more of an update at times on the progress (partner) was making.” (Participant 2)

Fathers wanted to know the frank details, of the illness, the treatments and how they could help. One skilled communicator managed to get this information.

“...what worked best for me was being able to sit in on consultations (partner) had with the psychiatrist and being given quite detailed kind of appreciation of what they thought would help her. So what worked best was kind of quite frank discussions about what the problem was and what the medication could do and that kind of thing. And quite clear guidance as to what exactly I could do.” (Participant 3)

Being fully aware of the situation creates a good grounding for the father to cognitively appraise the situation and apply adaptive coping mechanisms, not only to manage his own emotions but adapt to the situation in a way which optimally supports his family.

Table 4 displays which categories participants discussed.

5.2. A model of how fathers manage themselves and other relationships during their partner and baby's admission to a perinatal mental health unit.

This study proposes a model of how a father manages himself and other relationships when his partner and baby are admitted to the perinatal mental health unit (Figure 3). The process is initiated when the mother develops a perinatal mental illness requiring hospital admission. The father then begins a process of adaptation to the unit. Each father will have individual demands on him such as distance to travel which affects the time he can spend visiting. The partner's illness is a demand which varies for each family. The severity of the illness, the fathers understanding and the family's prior experience of mental illness will affect the burden of the demand, and the stress experienced by the father. The fathers understanding of the illness can be altered by acquiring knowledge. Fathers have varying amounts of social support to help them with the demands of their partner and child being hospitalised, the staff too can be a source of support. The father's attachment style and individual personality factors affect the ease with which they access support. Individual father variables, such as their belief in their abilities to care for their partner and child, impact upon how they behave in the unit and how well they are able to acquire knowledge and skills.

Each individual father has a combination of demands, supports and individual appraisals which impact on the coping methods they choose. Yet there are similarities in coping styles chosen as fathers try 'to take each day as it comes' for example. Coping styles chosen will affect the father's emotional reaction depending on how successful they are.

The model suggests the main way to impact on the fathers experience is though

aiding the acquisition of skills and knowledge. This can be done through increased verbal communication and modelling of desired behaviour by staff. Fathers will vary on how readily they are able to acquire knowledge due to their anxiety, attachment style, personality, and their beliefs about the situation and their role. Fathers who fail to acquire knowledge can be left feeling uncertain. The quantity and quality of their knowledge affects how they spend their time in the unit.

Within the unit fathers divide their time between time with their baby, time with their partner, time for older children to be with their mother and baby, or time with the whole family together. Fathers prioritise their time depending on how they have adapted to the unit and the coping strategies they have chosen.

Developing an attachment between the baby and the father is affected by the father's availability and his ability to respond to the baby's needs sensitively. The fathers regard the importance of the mother-baby bond being of greater significance than their own bond. Their opportunity to bond is reduced whilst the baby is hospitalised. The fathers cope with concerns about bonding by believing the baby is too young to do much, however fathers feel that once the baby reaches six months old fathers will be missing out more on opportunities to interact. This is particularly a concern for fathers who have experienced long admissions. Fathers spend more time with their partner when either one of them were struggling to manage, for example when the father felt the mother needed a break from childcare. The interactions with the partner are affected by how well fathers understand and incorporate her illness. How a father spends his time in the unit feeds back into his opportunities to acquire skills and knowledge, and allows him to test and modify his coping strategies.

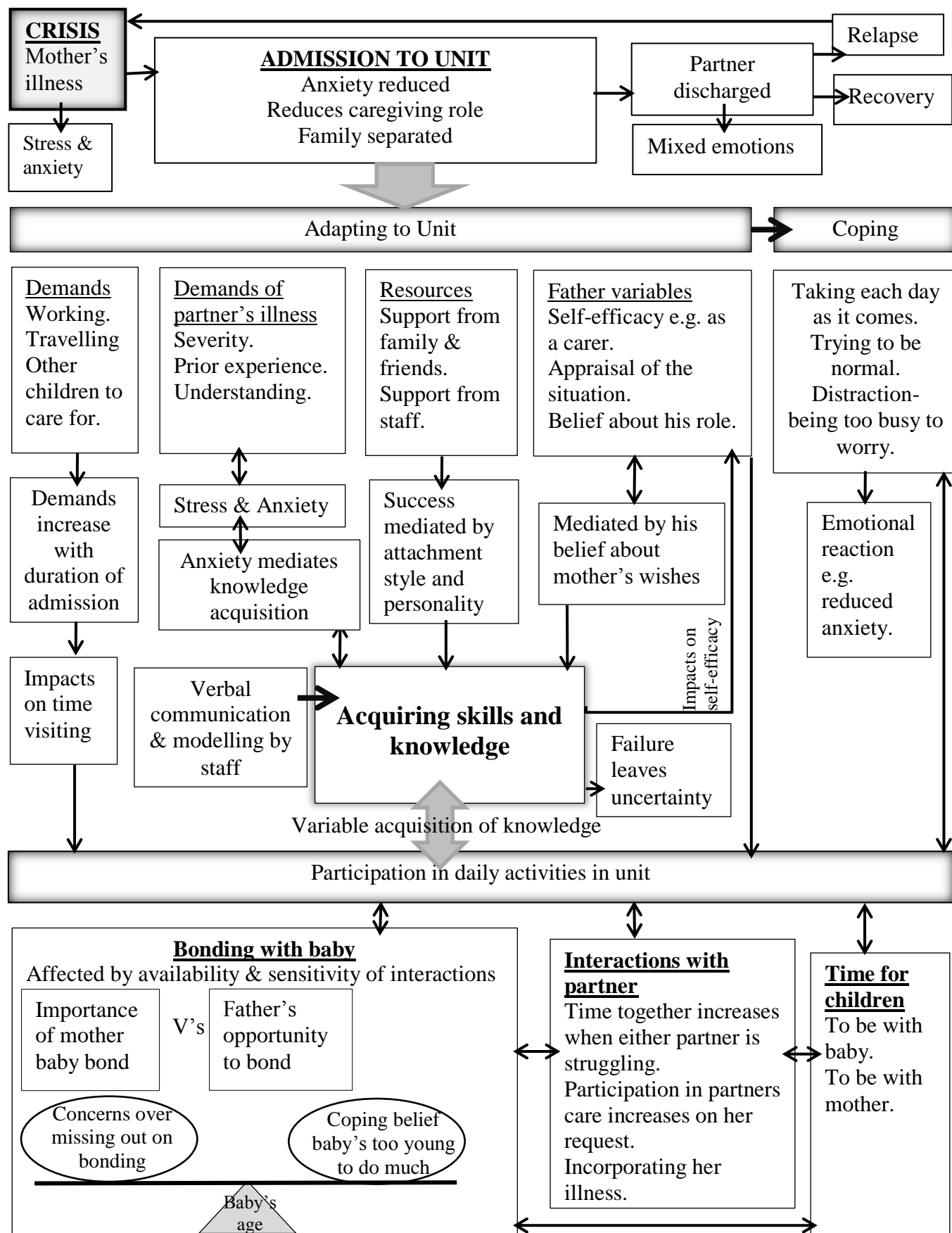


Figure 3. A model of how fathers manage themselves and other relationships during their partner and baby's admission to a perinatal mental health unit.

Table 4. Categories discussed with participants (1 of 2)

M = mentioned spontaneously by participant C = subcategory carried forward through reintroduction by interviewer.

**Managing the Self &
Other Relationships**

		Participant Number							
		1	2	3	4	5	6	7	8
Bonding with baby									
	Importance of mother being with baby	M	M	M	M	M	M	M	M
	Father needing to bond	M	M	M	M	M	M	M	M
	A fleeting figure	M	M	M		M	C	M	M
	Feeling left out	M	M		C	M	M	M	M
	Making time for siblings to bond	M	M	N/A	N/A	M	N/A	N/A	N/A
Keeping the family together									
	Relationships under pressure	M	M	C	M	M	M	M	
	Trying to be Normal	M	M	M	M	M		M	M
	Relying on support from family & friends	M	M	M	M	C	C	M	C
	Adjusting the couple relationship	M	M	M	M	M	M	M	C

Table 4. Categories discussed with participants continued (2 of 2)

M = mentioned spontaneously by participant C = subcategory carried forward through reintroduction by interviewer.

Managing the Self & Other Relationships

		Participant Number							
		1	2	3	4	5	6	7	8
Feeling contained	Relief of admission holding care	M	M	M	M	M	M	M	M
	Appreciating expertise	M	M	M	M	M	M	M	M
	Welcoming but not quite home	M	M	M	M	M	M	M	M
	Mixed emotions on discharge	M	M	C	M	C	C	C	M
Feeling overwhelmed									
	Experiencing anxiety and stress	M	M	M	M	M	M	M	M
	Feeling watched		M	M	M	M	M	M	M
	Life turned upside down	M	M		M	M	M	M	
	Travel and work pressures	M	M	C	M	M	M	M	M
Experiencing and managing uncertainty									
	Taking each day as it comes	M	M	C	M	M	C		M
	Understanding illness	M	M	M	M	M	M	M	M
	Understanding treatment	M	M	M	M	M	M	M	M
	Communication with staff	M	M	M	M	M	C	M	M

6. DISCUSSION

6.1. Personal Reflections

Throughout the research process I kept a reflective diary which aided the development of my grounded theory; example memos are displayed in appendix 11. During the interviews I was struck by how I was hearing a rarely told story. Fathers had experienced a distressing time when the mother's illness began, and the interviews had a therapeutic quality as fathers reflected on their experience and came to new conclusions. I wondered if the interview itself was an empowering experience. Some participants appeared more open than others about what had happened; I was aware how difficult and even traumatic some of their experiences had been, yet the emotion associated was not always freely flowing. As Arendell (1997) wondered in her study I too wondered if fathers were promoting a strong masculine identity to myself, a female researcher, by appearing emotionally strong. However in the detail of their narratives they were open and expressive. It registered with me that professionals at the unit may also see a composed father doing the best for his family and not realise he too may need support.

I had come into this process open minded. Research in this area had developed collaboratively through discussions with colleagues. My expectations were that interviews would reveal a variety of experiences, which they did. I anticipated fathers bonding would be affected by the admission but the intricacies and complexities of this were far richer than I had imagined. One category which I thought may have arisen which was not in the father's narratives was a sense that they needed to bond with the baby more, and take a greater role in childcare, because of the mother's mental illness disrupting bonding. Instead fathers try to maintain the

mother-baby bond and take their cue from the mothers regarding childcare.

I had not worked in the Mother and Baby Unit during my clinical psychology training so therefore did not know the mothers involved, or have experience of what it may be like for the fathers. I feel this aided my exploration of the experience through the father's eyes. Through their experience I built my own understanding.

6.2. A review of the results in relation to the literature.

This study provides a unique insight into an understudied area. There was no individual model in the literature which could explain how fathers manage the experience of their partners and babies being admitted to the unit and how he then develops his relationship with his infant. Therefore this grounded theory incorporates models from several fields. The main structure of the model is influenced by Lazarus & Folkman's (1987) cognitive relational theory of emotion and coping. It was also heavily influenced by McCubbin & McCubbin's (1993) resiliency model of family stress, adjustment and adaption, and Bowlby's (1969, 1988) attachment theory.

This study's findings share similarities with the literature on fathers whose partner has postnatal depression. There was a strain on the couple's relationship (Boath *et al.* 1998; Meighan *et al.* 1999; Webster, 2002). Fathers felt the illness had an effect on the whole family (Webster, 2002) and he tried to keep the family together (Meighan *et al.* 1999). Fathers felt overwhelmed by their partner's depression (Davey *et al.* 2006) and wanted more information about the illness (Webster, 2002). As in this

study, literature on Scottish first-time fathers found support from family and friends was important (Bradley *et al.* 2004).

Similar to findings by Goodman (2008), this study found qualitative evidence that the father-baby interaction was affected by what he thought his partner felt about her relationship with their baby. When the father felt the mother was struggling with the baby he would spend time with her away from the baby. He would restrict his interactions and allow the nurses to care for the baby so he was not the more successful caregiver. When communication between the couple were good, and the mother encouraged his interaction with their baby, the father seemed to do more.

Unlike the literature which shows maternal perinatal mental health is associated with paternal mental health (e.g. Harvey and McGrath, 1988; Lovestone and Kumar, 1993) this study did not find any symptoms indicative of a diagnosis of depression, anxiety, or stress in this population, as measured by the DASS-21. Although, for five of the participants their partner had been discharged and their narratives suggested they had considerably more symptoms at the time of admission. Overall this study is strongly supported by its similarities with past literature but captures and interprets the father's experiences within the specific perinatal unit setting.

The main aim of the study was to investigate the father's paternal role and how he develops his relationship with his child when his partner and child are admitted to a Perinatal Mental Health Unit. Early in the study it became clear the father's role was complex, he had to develop his paternal role whilst managing the demands of the illness and admission and ensuring all family relationships were maintained. Similar

to findings by Marks and Lovestone (1995) and Pleck and Stueve (2004) this study found the father's paternal role and his relationship with his child were developed in conjunction with the mother. The fathers tended to prioritize the mother-baby bond and would consciously consider their own interactions with their baby so not to jeopardize the mother's bond. The fathers assumed a range of roles which resonates with Lamb's (2010) discussion that fathers encompass multiple roles including breadwinner, caregiver and playmate. The roles fathers assumed in this study depended on the demands on them, their own beliefs, and their beliefs about what their partner would want them to do. Hops *et al.* (1987) found fathers did more childcare duties when their partner was psychiatrically unwell. This did not seem to be the case when their care was held within the unit (although there was not a comparison group) yet it did appear the fathers who did more childcare felt they were doing it to give their partners a break.

The admission to the unit makes the development of an attachment relationship between baby and father more difficult as they are separated. Bowlby (1969) suggests one of the essential components to form an attachment is the caregiver's continuous relationship with the infant. The longer the admission and the less frequently a father can visit the more difficult establishing attachment will be. However, availability of the parent is not sufficient to form secure attachment. The parent needs to be able to interact sensitively to the baby's needs (e.g. Gerhardt, 2004). When the father is concerned about affecting the mother-baby bond, feeling anxious, or is struggling to become involved in care giving he is unlikely to be able to respond sensitively to the baby's needs. Brown *et al.* (2007) found father's

sensitive parenting was more important than time with their child in the formation of secure attachment. So children formed secure attachment relationships with their father regardless of how much their father was involved with them if the father displayed sensitive parenting behaviours. Additionally, if fathers used less desirable parenting styles, a greater amount of involvement with their infant was related to a poorer attachment relationship. Their study cannot be directly compared to families in the perinatal unit as the average time a father spent involved with the child in Brown *et al.*'s (2007) study is 628 minutes over a 2 day period which is more than many of the fathers in the unit. However, the importance of sensitive parenting should be taken into consideration. Those who acquire the skills and knowledge to parent positively, perhaps through improved communication and exchange of childcare skills between professionals and fathers, may be more likely to achieve a secure attachment relationship irrespective of time together. The formation of a secure attachment relationship is protective for the child's mental health (Bowlby, 1969). Furthermore, fathers played a role supporting their partner, this was partially to maintain their relationship but also enhanced the mother-baby bond, which is a role previously described by Lamb (1997).

Fathers felt anxious when their partner became ill. Then felt relief that the unit was looking after their partner and they appreciated their expertise. In this way the fathers felt contained by the unit. By responding sensitively to a family's needs healthcare professionals can provide the main functions an attachment figure would; to create a secure base and reduce anxiety (Adshead, 1998). When trust develops, through a consistency of interactions, anxiety can be further reduced (Adshead, 1998).

However, although the environment of the unit was welcoming there was a sense it was not as comfortable as home and fathers were aware of surveillance of the patients and themselves.

As discussed there were similarities between findings in this study and studies on father's experiences when his partner had postnatal depression. Fathers had to manage demands on them such as working, caring for other children, and travelling large distances. The experience of a family member having mental health difficulties was a new experience to several fathers. All fathers were aware there was a great deal of detailed information that could have been shared to reduce their uncertainty about the illness, the treatment, and the duration of admission. The experience was something the fathers had to cope with and therefore models of coping and resilience (e.g. Lazarus & Folkman, 1987; McCubbin & McCubbin, 1993) were useful in understanding the experience.

Fathers who felt encouraged by professionals to do more caregiving did appear to participate more and appeared more confident in their abilities, or to have greater 'self-efficacy' (Bandura, 1977b) as a caregiver. Some fathers experienced the staff tutoring them on childcare which increased their skills. The majority of the fathers did not feel professionals were involved in what they were doing with their child. A minority of fathers felt left out of childcare activities when the nurses became involved in caring for their baby. Father's interaction with their child is vital. The amount of stimulation parents provide to their infant through interacting and playing is essential for their intellectual development (Carr, 2006). Furthermore, the baby

learns social skills through interactions with caregivers, by making the interactions highly pleasurable, such as through play, the baby becomes 'hooked' on interacting, and the baby's capacity for emotional regulation and social interactions are developed (Gerhardt, 2004). This is an area which could be improved with professionals appropriately modeling how fathers can become involved in childcare.

The fathers wanted to be involved in both their partners care and childcare. However, father's attachment style, personality, and their dismissal of difficulties all impact on how easily they establish communication with staff members. By increasing staff member's awareness some fathers are struggling and find it difficult to ask for help, the staff could approach fathers first. By including fathers, increasing their knowledge and skills through improved communication and modelling of appropriate behaviours fathers could facilitate the mother's recovery and successful return home.

This study's findings share similarities with literature about carers for people with mental illness. Factors found to affect the burden on carers include the severity of the illness, and length illness and length of hospitalisation (Dyck *et al.* 1999). Askey *et al.* (2009) conducted focus groups for Fifty-six participants with experience of psychosis services in the NHS, including carers. They found carers thought communication with professionals was difficult and they felt professionals did not listen to them, or involve them in their relative's care, which increased burden and stress. There can be a mismatch between patients and carers beliefs about the difficulty of caring. Cleary *et al.* (2006) studied carer involvement for 200 patients and 135 carers experiencing mental health inpatient stays. They found carers felt

more burden than the patients perceived them to, patients particularly underestimated the impact of a strained atmosphere between them. Understanding and acknowledging there may be a discrepancy between the mothers and fathers ideas about the burden of care may help the couple cope and aid communication between them.

In a systematic review of literature on family carers for people with severe mental illness Rowe (2012) found carers 'struggled to cope with the unexpected and unfamiliar demands of a severe mental illness' (p.80.). This is similar to many of the fathers' experiences. Rowe (2012) found the barriers to carers providing effective care were the carer's ability to cope, attitudes of staff not engaging carers, and inadequate communication between professionals and carers. Again this shares similarities to fathers experience in the unit, their coping skills affect their participation in the unit and caring for both partner and child. Fathers wanted to be more included by professionals and to be given more information. Rowe (2012) concluded both professionals and carers could do more to overcome the barriers.

Fathers did not express much knowledge of their partner's illness or treatment.

Fathers reported high stress and anxiety levels when their partner became ill. The effect of anxiety on information seeking and retention will now be considered.

Individuals are not always motivated to seek information about illnesses, prevention behaviours or treatments, particularly if it is distressing (Turner *et al.* 2006).

Psychosocial stress has been found to impair memory retrieval of new information, and emotionally arousing information was more likely to be forgotten under stress (Kuhlmann *et al.* 2005).

In an experimental study on health information seeking, participants were randomly allocated to groups which induced the belief they were either a high or low risk of developing skin cancer or diabetes. People who were at high risk and had high self-efficacy in their ability to prevent and control the illness displayed the most information-seeking behaviour. People who were at high risk but had low self-efficacy sought out information but retained much less information than those with higher self-efficacy or lower risk. The study hypothesised that those with high risk but low self-efficacy were more anxious and their anxiety led them to seek information but lowered their ability to retain it (Turner *et al.* 2006). Therefore, the level of anxiety a father is experiencing and his self-efficacy is likely to determine what information he seeks and what he remembers. Providing written material for example psychoeducation on his partner's illness may aid the father's acquisition of knowledge.

6.3. Clinical implications

There are guidelines for the care management of perinatal mental health such as the Scottish Intercollegiate Guidelines Network (SIGN, 2012) and National Institute for Health and Clinical Excellence (NICE, 2007) guidelines. Both recognise the adverse effect postnatal mental health disorders have on the partner and family. The SIGN guidelines recommend good communication between family and professionals to ensure against risk to children. The NICE guideline goes further to promote the inclusion of fathers with recommendations professionals develop careplans in

collaboration with the mother and her partner, and provide information on the mental disorder its course and treatment. NICE recommends professionals should assess and address the father's needs including the impact the mother's mental disorder may have on their relationship.

In order to reduce fathers' uncertainty and anxiety, and for the fathers to be able to optimally support the mothers, it is essential they develop an understanding of her illness, her treatment and what he can do to facilitate her recovery. This can be done by increasing the flow of communication between professionals and fathers and encouraging their inclusion in meetings regarding their partner. One-to-one sessions may be helpful to elicit fathers concerns and answer individual questions. Specific information leaflets for fathers detailing the expectations of them in the unit and common concerns may facilitate discussion. One study has investigated the effects of including fathers in their partners' psychoeducational treatment for postnatal depression (Misri, Kostaras, Fox & Kostaras, 2000). They found father involvement improved treatment outcomes for the mothers, compared to the control group.

The findings show the baby's attachment to the father may be difficult to establish particularly over long admissions when the father visits infrequently. The fathers clearly have concerns about bonding particularly when the baby is older. As poor attachment is linked to later emotional and behavioural problems every effort should be made to ensure attachment relationships are formed between the baby and its primary caregivers. There may be sparse opportunity to increase the amount of time a father spends in the unit. Brown *et al.* (2007) found sensitive parenting to be more

important than time together in the formation of secure attachment. Furthermore, father's positive involvement with their child when the mother is depressed has been shown to reduce internalizing behaviour problems in childhood (Mezulis, Hyde, & Clark, 2004). Therefore it may be beneficial for professionals to increase father's skills in sensitive parenting by modelling appropriate childcare, and ensuring they feel included.

Considering the experience has an effect on the couple's relationship which the father attempts to adjust to, and the literature highlights couples with poor relationships are significantly at risk of depression during the first year of being a parent (Matthey *et al.* 2000). The effect on their relationship should be taken into consideration in an attempt to minimize the risk of depression. Father's awareness of common relationship strain could be increased through leaflets. Again a one-to-one meeting with a professional may be helpful to elicit fathers concerns and difficulties. Furthermore, couples sessions could be utilised to work through any presenting difficulties, and couple interventions are recommended in the SIGN guidelines (2012) for the treatment of postnatal depression.

Fathers in this study experienced many demands and felt 'watched' which impacted on their participation in the unit, and left them feeling overwhelmed. The need to observe the fathers was not always discussed with the fathers depending on the circumstances. In order to reduce fathers feeling overwhelmed, and provide fathers with the best opportunity of showing he can care for his partner and child, fathers should be informed of the observation and given the opportunities to learn the

desired skills. The researcher recognised fathers may say they were ‘fine’ when the content of their experience appeared overwhelming. This, and father’s attachment style, personality, and level of anxiety may make it difficult for professionals to engage them and therefore affect how well communication may be established. Increasing professional’s awareness of these factors may facilitate interaction.

Twenty-one Mother and Baby Units in the United Kingdom were contacted regarding services for fathers, 13 units replied (two of which are not currently operational). Responders unanimously felt it was important to provide a service for fathers. All units offered some level of services to fathers. Most commonly the units offered one-to-one sessions for information and emotional support. Four units offer ‘fathers groups’, three offer couple or family work, and two mentioned the leaflets they provide (Perinatal Mental Health Units, personal communication, January 2012).

6.4. Further research

Encouraging and facilitating open communication with fathers using written material, face-to-face interaction, and modelling of behaviour could increase the father’s knowledge and skills. The effectiveness, acceptability and time constraints of each method could be tested as the perinatal units are limited in what services they can provide for fathers.

A hypothesis proposed by the model is that increasing a father’s knowledge and skills (e.g. regarding the illness, treatment, and expectations of childcare) will affect

their participation in daily activities in the unit, their stress and anxiety, and their self-efficacy as a carer for their partner and baby. Research is needed to validate each of these associations.

This study presents a small amount of evidence the mother and baby's hospitalisation affected other children in the family. Children appear distressed by the separation from their mother, and it could affect their attachment relationship. Furthermore the admission appears to interrupt the siblings bond. This has not previously been researched and it would be important to investigate the complexities of this through qualitative investigation.

Including fathers in discussions regarding his partner's illness and care-planning meetings is likely to increase the father's involvement in his partners care and knowledge and self-efficacy as a carer. This could be introduced and reviewed with the mother, father, and professionals to design an inclusive and helpful service for the family.

Qualitative research could be conducted with professional in the unit regarding their expectations of fathers in terms of their caregiving to mothers and babies. This would be helpful information to produce guidelines for fathers as some thought they were doing the right thing by their chosen method of caregiving later to find out staff had different expectations.

6.5. Methodological critique

6.5.1. Limitations

Previous research strongly links maternal and paternal mental health yet none of these participants had current depression or anxiety. There is the potential those who did not volunteer were struggling more. Also ‘experiencing a high level of distress’ was an exclusion criteria, but this only excluded two fathers. If there were a significant proportion of fathers who were distressed or experiencing their own mental health difficulties who did not wish to participate then this could have biased the results. Distressed fathers not wanting to participate may also imply fathers may struggle to tell professionals they require help. This study did not assess the mental health of all the fathers whose partner was an inpatient, and future studies should do this in order to understand whether those fathers who chose to participate are representative of this population. However, the qualitative findings did support fathers were stressed and anxious at the time their partner was unwell.

A second limitation is the lack of socio-demographic information on fathers who did not participate. Again this makes it difficult to make any direct comparisons between participants and non-participants, and decide if those who took part were representative of this population. All participants were married, and the majority of participants had professional occupations, future studies should assess all father’s socio-demographic characteristics to allow conclusions to be made about how relevant the sample is to this population.

The recruitment method only resulted in 8 out of 55 potential participants taking part. Previous studies of fathers whose partner had postnatal depression in the community such as Meighan *et al.* (1999) and Webster (2002) also had eight participants but do not mention how many fathers were invited to participate. The two previous inpatient studies (Harvey & McGrath, 1988; Lovestone & Kumar, 1993) questioned *every* father, whose partner was in the mother and baby unit, regarding psychiatric illness. The present study was inclusive in terms of inviting participation, so perhaps the low uptake was due to issues such as the time commitments of being a new parent. Low uptake makes it difficult to know if the views of the eight participants are representative of the whole group, however there was a great deal of consistency between the 8 participants. Low uptake also meant theoretical sampling was not used. However, the participants did represent a variety of ethnicities, distances from the unit, number of children, single and twin births, and current inpatients versus past inpatients. Because of this variety, during the analysis it did not become apparent that further information needed to be gathered from a certain sample in order to refine a category.

The potential impact of whether the mother was an inpatient at the time of interview should be considered. Only 3 participants currently had their partner in the mother and baby unit and each made a request that the interview be kept to a maximum of one hour, this was sufficient to cover the questions but further time may have allowed greater elaboration. However no difference in the quality of the narratives was apparent between groups as both provided rich and detailed descriptions, and were reflective on their experiences. Interviewing fathers currently and previously in

the experience may have added to the richness of the findings as it allowed greater exploration of the full experience.

Another limitation is the narrow generalizability of qualitative results; this sample is specific to the perinatal unit and represents those fathers' opinions at one specific time. Findings are only generalizable to father's experiencing their partner and baby's admission to a Perinatal Mental Health Unit.

6.5.2. Quality standards met within this study

Credibility has been established through the systematic comparison between interview data and categories, and categories and literature, during the coding process. Memos have been recorded and referred to throughout this process. This creates strong links between the data and the resulting grounded theory.

The majority of categories appeared saturated after the analysis of participant five's interview. Further participants clarified some issues on understanding the illness and communicating with staff before saturation was complete. Nvivo was utilised to organise coding (appendix 12). Several transcripts were independently coded by clinical and academic supervisors and then discussed with the researcher.

Consistently the same categories were pertinent. This process, and memoing of the researcher's assumptions, helps to eliminate the researcher's own biases. The categories were then discussed with a research participant. This study had resonance as the participant strongly recognised the majority of categories as being relevant to his experience, and all categories made sense to him. His responses helped to

describe and finalise the categories displayed in the results section. Participants' responses which contradicted the data were included in the results to explain how father's experiences differ; this increases the validity of the findings.

6.6. Concluding statement

The main findings are that the father has multiple demands on him during his partner and baby's admission to the perinatal unit which impact upon his participation in the unit and the interactions between family members. The father's bonding with his baby is affected by his availability and the sensitivity with which he can respond to the baby's needs. Father's concerns about bonding are heightened when the baby becomes more active and during long admissions. Fathers who were most successful at managing their own experience and managing relationships with other family members, including their baby, were those who could visit frequently and who successfully established communication and acquired knowledge and skills from professionals. It is recommended professionals involve fathers to increase their knowledge of the illness and treatment. Through improved communication and modelling, his skills as a caregiver could be increased which could reduce stress and potentially lead to improvements in their partner's care and baby's attachment.

7. JOURNAL ARTICLE

Keeping the family together and bonding with baby: a father's role when his partner and baby are hospitalised in a perinatal mental health unit.

Child: Care, Health and Development.

Word count: 4997

7.1. Abstract

Objective

To explore the father's paternal role and relationships when his partner and baby are admitted to a Perinatal Mental Health Unit.

Background

Establishing attachment in the first months of life is crucial for infant mental health.

Parental mental health and separation can negatively impact attachment.

Furthermore, maternal postnatal mental health is known to affect the father's well-being which could impact on his ability to parent sensitively.

Method

Grounded theory methodology was used. Eight fathers recruited from perinatal mental health units in central Scotland were interviewed. Transcripts were analysed and compared by researchers. Resulting categories were checked with one participant.

Results

Fathers described a difficult experience which they managed whilst creating and maintaining family bonds. Long admissions with infrequent visits were most difficult. Fathers wanted to bond and had concerns about bonding. They aimed to preserve the mother-baby bond. Fathers relied on family support. The couple's relationship was strained. Fathers experienced anxiety regarding the illness and felt relief when their partner was admitted. Fathers were uncertain about illness and treatment and desired improved communication with professionals.

Conclusion

Severe maternal postnatal mental illness and inpatient admission affects fathers.

Fathers were not consistently available to babies, which could affect attachment and child development. Recognition of the father's experience and increasing father's knowledge of illness and skills in caregiving is recommended.

Keywords: father; paternal; postnatal; mother; baby; inpatient.

7.2. Introduction

Establishing attachment in the first months of life is crucial for infant mental health. Maternal mental health can negatively impact attachment. One purpose of Mother and Baby Mental Health Units are to promote maternal-infant attachment by keeping them together, as separation from a primary caregiver also impacts negatively on attachment. However, an often necessary consequence of admission is they are separated from the rest of the family. Furthermore, maternal postnatal mental health is known to affect the father's well-being directly by an increased likelihood of depression, and indirectly via a compromised partner relationship. Both these factors could impact on the father's ability to parent sensitively. This qualitative study will explore the father's paternal role and relationships when his partner and child are admitted to a Scottish Perinatal Mental Health Unit.

Bowlby's (1969) attachment theory explains the impact of the emotional bond between a caregiver and a child on the child's psychological development. The first six months after birth are crucial to establish this bond (Bowlby, 1969). Children learn how to express their emotions through the way their attachment figure responds to them. It is this aspect of attachment theory which differentiates between an individual developing a resilient personality or becoming prone to mental health difficulties. Once a pattern of attachment is developed it tends occur throughout the lifespan (Bowlby, 1988).

When a mother is depressed she can find it difficult to respond to her baby, the mother can be withdrawn and apathetic. The babies get used to a lack of positive

interactions and interact in a depressed style (Gerhardt, 2004). In contrast, when a mother is anxious she may be over-involved with the baby and continuously stimulating them, which results in the baby being over-aroused (Gerhardt, 2004). These mother infant interactions do not lead to the development of a secure attachment style, or good emotional regulation. Likewise, if a father is experiencing mental illness both may struggle to respond to the baby's needs appropriately.

When new mothers in Scotland experience severe postnatal mental illness such as depression and puerperal psychosis they may be admitted to one of two Mother and Baby Mental Health Units in central Scotland. These 6 bedded wards provide assessment and treatment for the mother whilst promoting attachment.

Studies of fathers when their partners had postnatal depression found fathers experience a strain on the couple's relationship (Meighan *et al.* 1999; Webster, 2002). These studies had several limitations but crucially they were from community samples where the mother was at home within the family, their experience may differ from when they are in psychiatric units. There is sparse research on fathers when their partner and child are admitted to a perinatal Mother and Baby Unit, yet the evidence shows they are vulnerable. Forty-two per cent (Harvey & McGrath, 1988) and 50 per cent (Lovestone & Kumar, 1993) of these fathers met diagnostic criteria for a psychiatric illness. Lovestone and Kumar (1993) reported a limited amount of qualitative data; the men discussed a stark contrast between the excited anticipation of the baby's arrival and the reality of coping with an empty house, work, and visiting their ill wife. A feeling of sadness was emphasized by seeing the unused

prams and toys at home. This study benefitted from adequate control groups and a good yet small sample size. Importantly, this is the only study which begins to investigate the fathers experience when his partner and child have been admitted to a psychiatric Mother and Baby Unit.

Father-infant interactions are effected by maternal mental health. Goodman (2008) found when the mother had postnatal depression the father displayed less optimal father-infant interactions, so they do not appear to compensate for the negative effects maternal postnatal depression can have on the child. However, father-infant interaction was influenced more by how the mother felt about her own relationship with the infant, than maternal depression. The quality of the couple's relationship also seems to affect parent-infant relationships. For example, Mantymaa *et al.* (2006) found when mothers had mental health problems a poor, disengaged marital relationship was associated with poorer mother-infant interactions. Therefore the father's role as a partner may influence the development of infant attachment.

7.3. Study Aims

A mother suffering from severe postnatal mental illness is a time of risk for a partner's mental health and the baby's psychological development. An admission to the Mother and Baby Unit aims to treat the mother and strengthen the mother-infant bond. Fathers can become the infant's attachment figure, but does admission to the unit interrupt this? The effect on the father's role and his ability to bond with the baby has not been researched previously.

- What is the father's paternal role and how does he develop his relationship with his child when his partner and child are admitted to a perinatal Mental Health Unit?

7.4. Method

7.4.1. Design

Qualitative research can be a useful tool for learning about a person's experience with a phenomena, uncovering what lies behind a phenomenon, and gaining fresh insights into something which little is known (Strauss & Corbin, 1990). This study uses Grounded Theory methodology. The purpose of Grounded Theory is to create a theory which illustrates, and remains faithful to, the area which is being studied (Strauss & Corbin, 1990). It involves moving back and forth between gathering data, coding, and analysis before returning to gather more data until categories are saturated (Charmaz, 2006).

7.4.2. Recruitment

Professionals at the national Mother and Baby Mental Health Units in Scotland were informed about the study and asked to identify potential participants. Fathers were given information about the study either face-to-face by staff, or by post. The researcher contacted interested participants to arrange an interview.

7.4.3. Inclusion criteria:

- Fathers of infants admitted to the Mother and Baby Unit during the recruitment period.
- Must have visited their partner and child in the unit.
- Must be over 18 years old.
- The infant will be under 12 months old when admitted.
- Fluent in English.

Exclusion criteria:

- Experiencing a high level of distress.

In Grounded Theory the researcher stops recruiting when the categories are "saturated", this is when gathering fresh data no longer triggers theoretical insights, or reveals new properties of the core categories (Charmaz, 2006).

7.4.4. Participants

Fifty-one fathers whose partner had been admitted to recruitment base one in the 1 year and 121 day long recruitment period were identified as suitable, as were 4 participants from recruitment base two (recruitment period 41 days). Eight fathers participated, three of whom had their partner in the unit at the time of interview. They were aged between 28 and 51 years (mean = 37.5, standard deviation (s.d) = 8.14) and all were married. Five participants were first time fathers, three had older children. Six participants were of White Scottish ethnicity, one was of White other British ethnicity and one participant was of Black African ethnicity. Six participants were employed full time, two were self-employed. All participants scored within the normal range on the Depression Anxiety Stress Scales (DASS-21; Lovibond & Lovibond, 1995) which is a valid and reliable measure (Henry & Crawford, 2005).

7.4.5. Data Collection

One-off, individual interviews were conducted and recorded. Interviews lasted between 49-103 minutes (mean 69 minutes). Interview questions needed to gather rich data without imposing preconceived ideas (Charmaz, 2006). The initial interview contained open ended, non-judgemental questions which allowed the participants stories to emerge, for example “Tell me about your experience of your partner and child being in the unit?” Interviews were transcribed, analysed, and new questions developed before the next interview.

Memoing the analytical steps and discoveries is central to the resulting grounded theory (Charmaz, 2006). Memos aided the development of the results and were made about expectations, thoughts about interviews, recruitment, and analysis.

7.4.6. Analysis

Line-by-line coding was used initially followed by focussed coding and theoretical coding. Transcripts were given to supervisors to analyse to compare ideas about emerging categories. This counteracts any bias of the researchers experience affecting the analysis.

To improve validity of the results feedback can be obtained on the study’s findings from participants, and responses are then incorporated into results (Mays & Pope, 2000; Willig, 2008). This was done with one participant.

7.4.7. Ethical issues

The study received ethical approval from the South East Scotland Research Ethics Committee, and Caldicott Guardian approval. Fathers were given 24 hours to consider participation after being given the study information sheet. Participation was voluntary and they were free to withdraw. Participants were supplied with contact details for mental health organisations in case they felt distressed by the interview. They were informed child protection issues would be reported. All participant data were anonymised and stored securely on NHS password protected computers and in locked cabinets, it will be stored for 5 years before secure disposal.

7.5. RESULTS: MANAGING THE SELF AND OTHER RELATIONSHIPS

The overarching category ‘managing the self and other relationships’ captures the father’s experience and how he tries to understand and manage it, and the role he takes in relation to making and maintaining bonds within his family. The subcategories are Bonding with Baby, Keeping the Family Together, Feeling Contained, Feeling Overwhelmed, and Experiencing and Managing Uncertainty, see figure 4.

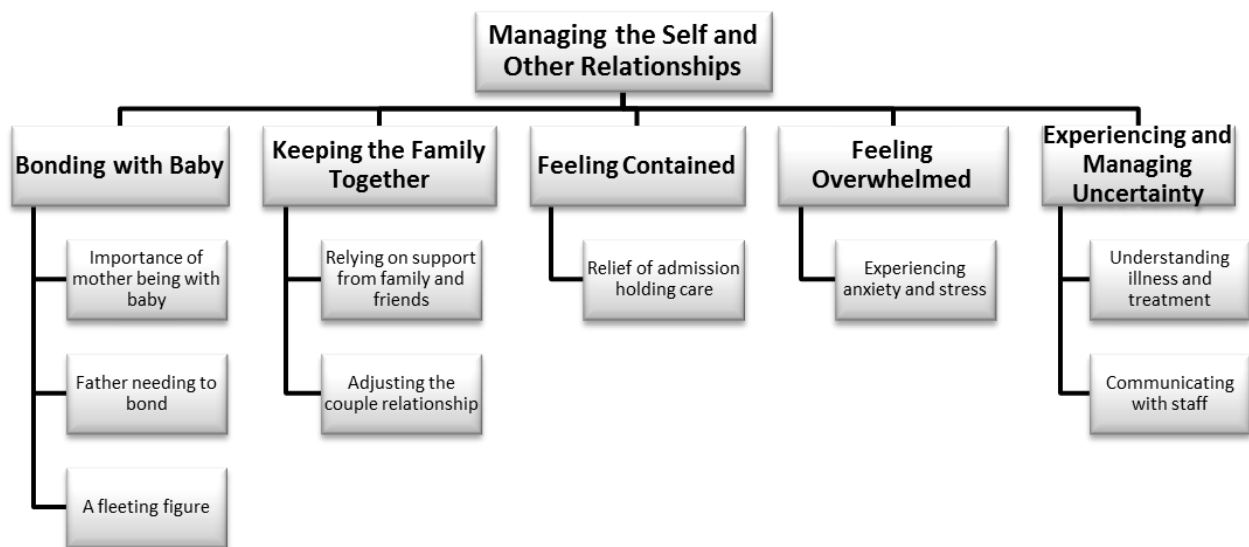


Figure 4. Categories of managing the self and other relationships; a father’s experience.

7.5.1. BONDING WITH BABY

7.5.1.1. Importance of mother being with baby

The father's strongly emphasised the importance of the mother being with baby, and felt reassured by them being together. The significance of the mother and baby being together was emphasised by having a mental health unit specifically designed to keep them together.

"I'm not sure what the evidence is here, or the factual information but ...I don't know if it is an old-fashioned thing to say but I do think there is a bond between a mother and a child, a baby and its mother. And I think there must be in a sense. Surely that's why there is a Mother and Baby Unit" (Participant 2)

This idea resulted in them aiming to strengthen and preserve the bond between their partner and baby, sometimes to the extent that they would restrict their own desires to interact with their infant.

"I think I was a bit cautious in the early days when I first started going down to Livingston. Maybe in some ways thinking to myself ...I suppose I did actually in the early days...thinking how important it was for (partner) and (baby) to be together" (Participant 2)

The fathers tended to take their cue from the mother and tailor their interactions with the baby to be supportive for her. So if she needed a rest from childcare the father would do more, or they may spend time together without the baby.

7.5.1.2. Father needing to bond

All fathers spoke of being involved in childcare in the unit. They wanted to get to know their baby, and meet their needs. During long admissions, and particularly when the father was unable to visit frequently, the fathers had greater concerns about bonding.

“As much as she obviously recognises me. Erm it does still worry me that, obviously because I have been away for so long but I can see she recognised. Being away working for so long and being back, will she still remember me as a dad? ...She has still remembered. And I have known since first of all. My wife said do you see how she has reacted to me (father) differently to any of the other nurses in here.

So your wife sort of reinforcing...

Yer. So (partner) emphasises that my daughter remembers me, she remembers her dad. Because as much as a 6 month old knows what a daddy is she recognises me as that most significant man in her life.” (Participant 5)

7.5.1.3. A Fleeting Figure

Fathers were concerned about being perceived as a ‘fleeting figure’ by their baby. They wanted to visit frequently and be involved in care so their baby could grow to know them. For fathers who were restricted in terms of visiting time there was a sense they were not able to be the stable figure sitting with their child for hours as they might at home.

“I would maybe do the feed at that point.

How did that feel?

It was always good to do. Felt as though you were being involved in the baby’s life rather than sort of this fleeting figure that rushes in and out every so often. So that was good.” (Participant 1)

Getting involved with childcare combated the concern of being a fleeting figure.

Fathers reassured themselves with the idea their infant may be too young to interact with much and to notice their absence, but for long admissions the worry loomed that their baby may not recognise them as an important figure in their life.

“Whether it be this is someone I see an awful lot, this is someone I don’t. But having said that, that is something I am not worried about, but I have in the back of my mind. I don’t want to use the word worried but it’s close to worry in a sense. I won’t want him to be here till he gets to that sort of age where he and I begin to sense some funny feelings from him. Or he sees me and he sees me as the one whose scaring him or something like that for the first few minutes. You know what ever, basically I don’t want him to grow, I don’t want him to get to the point where he is spending more than half the week not seeing his dad.” (Participant 7)

Fathers are handling any worries they have about separation from their baby by putting them on hold. They are reassured by mother and baby being together and are waiting until the family return home.

7.5.2. KEEPING THE FAMILY TOGETHER

7.5.2.1. Relying on Support from Family and Friends

Fathers received the majority of their support from family. The intensity varied but several participants received intensive daily help, on occasions even moving in with family. Fathers received both practical and emotional support and some acknowledged they would not have been able to cope without it.

“I probably wouldn’t be sitting here today if it wasn’t for my mother in law” (Participant 2)

Some fathers did not feel the need to rely on friends or family as much. However, it was clear that some fathers did not have a wide support network, and greater support from staff would benefit them.

7.5.2.2. Adjusting the couple relationship

When the mother experiences a severe postnatal mental illness it can be shocking for the father, particularly when the mother experiences changes in her personality. It can be difficult for the father to understand, particularly when he does not have knowledge about the illness or likely recovery. The experience of illness can affect the security he feels about their relationship.

“It is quite easy I am sure to think oh my goodness this is the end of our relationship because it’s not an illness where she is sick and she needs this medicine and she will be better after x weeks, you know.” (Participant 5)

All fathers spoke of having time with their partner, and the majority tried to be alone together. They felt they were supported in this by staff offering to care for their baby. There was a sense that fathers had to be protective of their wife, the protective role was important in the wife’s recovery. Participant 4 described his role as:

“Keeping her alive. Giving a reason to live. Coz she didnae”. (Participant 4)

Many of the fathers felt their partner relied on them for support. This reliance could both strengthen and strain the relationship.

7.5.3. FEELING CONTAINED

7.5.3.1. Relief of admission holding care

Fathers experienced a period of uncertainty and worry when their partners had been experiencing symptoms but had not yet received specialist help. Fathers felt relief when their partners were referred into the unit.

“I think at the time probably what I would...my overriding kind of emotion would have been relief that finally she was in a place where people understood what was going on.” (Participant 3)

The admission to the unit made the fathers feel better and provided hope of recovery.

“Overall I thought the experience was very good. It certainly did the mother the world of good. It has also made me feel better because that whole point, everything was quite, very upsetting and everything and obviously when she got to that unit she was finally receiving the help she was needing then as she got better it made everyone else, well it made me feel better in myself because then I could see things moving forward rather than things getting stuck and going backwards.” (Participant 1)

When it was time to be discharged some fathers experienced anxiety as they felt the care of their partner again going to be their responsibility.

7.5.4. FEELING OVERWHELMED

7.5.4.1. Experiencing anxiety and stress

All fathers discussed some anxiety and worry. Father's distress was particularly strong if this was their first experience of mental health difficulties, or when their partner's condition deteriorated.

"It was really scary, especially I think going home at night and things. Like just lying awake and then, I dunno, obviously I hadn't been sleeping well as well so the thoughts that (partner) was speaking to the psychologist, I was getting the same kind of thoughts. Not wanting to kill myself but just that I couldn't concentrate on anything. I couldn't relax because my mind was just racing..." (Participant 4)

This level of anxiety will affect how available they are to care for their partner and child. When fathers were confident their partner was managing her illness, and they felt admission was for a short assessment, they were less anxious. Fathers also spoke of stress related to travelling long distances to visit. When fathers had older children they also had to deal with their distress at being separated from their mother.

"The first four weeks in particular every night he cried. Things like that, as a father, when your wife, his mother is taken, when she is not in the environment he is used to, as in home. Dealing with that was quite hard." (Participant 2)

In order to comfort their children fathers aimed to reassure them, retain their normal routines, and maintain bonds with their mother and new sibling.

7.5.5. EXPERIENCING AND MANAGING UNCERTAINTY

7.5.5.1. Understanding illness and treatment

Fathers were uncertain of their partner's diagnosis, precipitating or maintaining factors. The father's understanding did not appear to be affected by the length of admission but may be a result of how fluently they could establish communication with staff.

"...for the last 3 months the diagnosis has been a bit...well it was only at that meeting (...) where the consultant said catatonic schizophrenia.

Was that the first time you had heard?

Well I have seen that and I have seen bi-polar disorder and I have seen depression and somebody had mentioned like a reaction to some sort of trauma."

(Participant 6)

A small number of fathers did not understand the serious nature of their partner's difficulties. For one participant, prior knowledge of mental health and the belief postnatal depression is common may have contributed to this. With hindsight he wishes he had found out more.

"I didn't think what was happening was strangely enough that concerning. Because, I mean, you hear about how often women experience postnatal depression and other things anyway. Erm and it's a relatively common occurrence and so if you are in that circumstance, if you are like me anyway, erm you are not immediately thinking oh dear this is horrific! You are thinking oh this is perfectly understandable, perfectly normal, erm lets just get on with things. Try and see some improvement here. Do the necessary steps to improve certainly my wife's situation and you know I really wasn't that concerned about it at all. Erm obviously that wasn't the attitude that was held by other people, but my concerns at the time were definitely for the way my wife was feeling." (Participant 8)

Fathers were uncertain about their partner's treatment plan, or duration of treatment. Those who had established good communication had the greatest knowledge of treatment. Some fathers had very little knowledge, they did not feel included in their partner's care, and they felt this relegated them from next-of-kin status.

“Erm nobody had ever really explained to me I don't think the real purpose of her being in the unit. I don't think anybody ever really sat me down and said, you know, “this is what we are hoping to do. Not just to keep your wife and daughter together” Erm it felt a bit strange at times. It almost felt like you were going down to visit somebody in hospital.” (Participant 2)

What contributed to fathers' uncertainty were difficulties establishing communication with professionals and their partner giving them the impression they were better than they were. Maybe due to their limited understanding fathers did not make many adjustments to their behaviour in order to facilitate her recovery.

7.5.5.2. Communicating with staff

Improved communication with staff could minimise uncertainty. All fathers felt communication could be improved. Some fathers were skilled communicators who were able to seek out information; others were more uncomfortable in this role. Although staff were always available it was only the more socially confident fathers who would use this opportunity to speak with staff, and be persistent.

*"I'm used to dealing with professionals and you know I speak to people for a living in a sense. So I always appreciated the more frank full explanations that I could get (...) **You got a lot of information. Do you feel you sought out people to talk to?** I think so yes. I think I did. I think sometimes you had to ask a couple of times. You had to convince people that actually you really did want to know what was going on. And you did understand what they were saying to you. But I think you find that when you are talking to doctors anyway." (Participant 3)*

The unit is designed as a service for the mother and baby, they are therefore the priority. The father recognises this; furthermore his partner and baby are also his priority. However, some fathers felt excluded by this.

"...in as much as (partner) is the patient it kind of feels like, you know, she is the patient so we don't really care about you sort of thing. But in as much as she is the patient they should realise she has got a partner, that's her husband, he is father of the baby, and whatever it is you are doing you need to get him involved basically." (Participant 7)

The fathers felt they should be included in their family's care. This may need to be initiated by staff as there was a sense fathers felt disempowered and were restricting their communication.

"I do phone yer. Maybe not as much as I should. Maybe that's the thing, maybe I should phone more often . and I'm going (incomprehensible) as time goes by I have phoned a few times. Maybe I should have phoned more often but again I think to myself if I phone more often they will think there's so and so on the phone again, you know!! I don't want to put myself, and I don't want to put the doctors in a way they will think that of me. Which means I am probably less likely to get the best information." (Participant 5)

This study proposes a model of how a father manages himself and relationships in the unit, see figure 5. Each father experiences a combination of demands and support which affects how he copes, his participation in the unit, and his relationships. His ability to acquire knowledge and skills from professionals (which is affected by his personality and attachment style) will affect his participation in the unit, relationships, uncertainty, and coping.

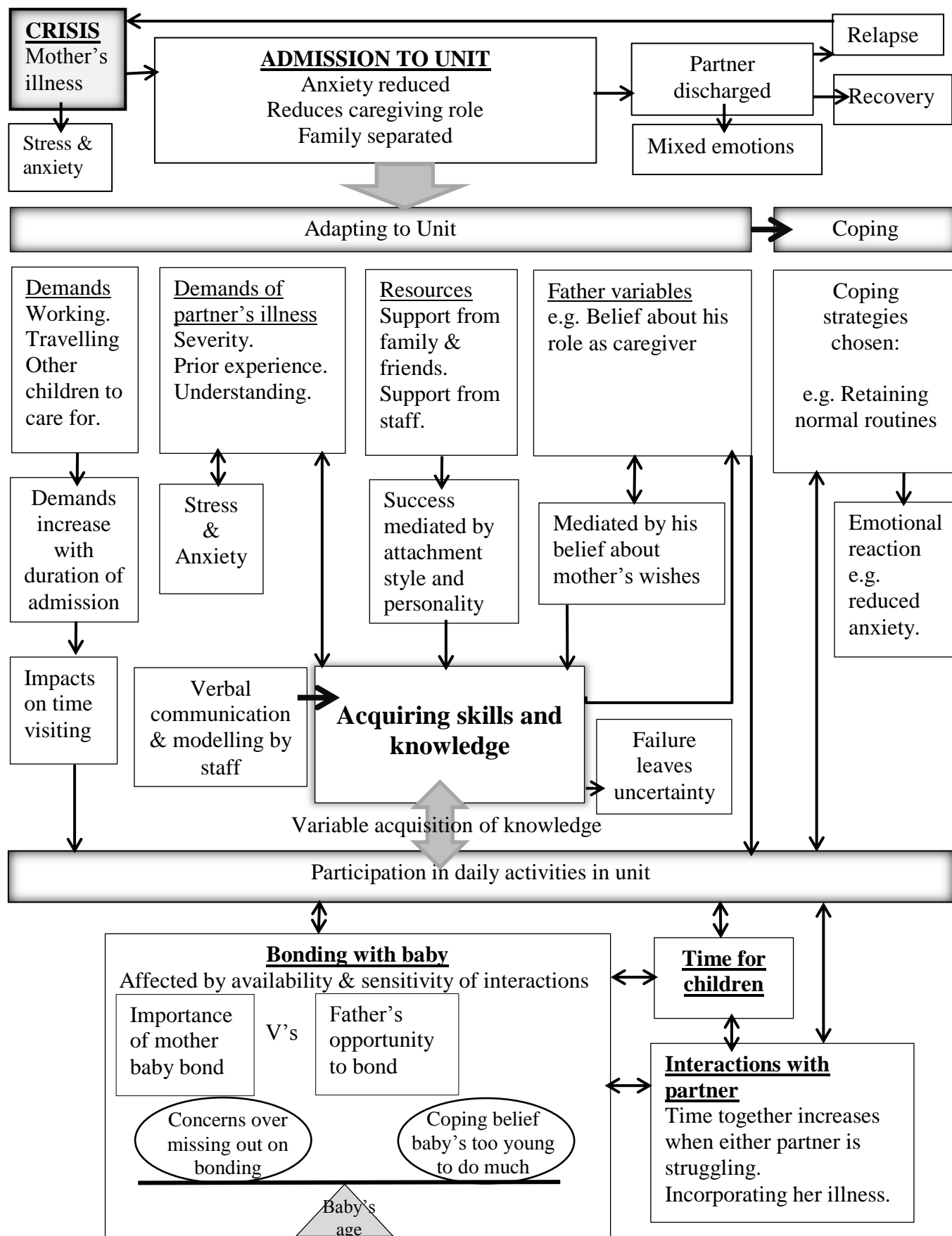


Figure 5. A model of how fathers manage themselves and other relationships during their partner and baby's admission to a perinatal mental health unit.

7.6. Discussion

This study provides a unique insight. The father developed his paternal role whilst managing the demands of the illness and admission and ensuring all family relationships were maintained. Fathers clearly wanted to bond with their baby. Admission to the unit makes the development of a father-infant attachment relationship difficult as they are separated. A caregiver's continuous relationship with an infant is an essential component to form attachments (Bowlby, 1969). Fathers were aware they were not consistently available to their baby and had concerns about bonding and being perceived as a 'fleeting figure'. The longer the admission and the less frequently a father visited the more difficult this was. Additionally, caregivers need to interact sensitively to their baby's needs to form secure attachments (e.g. Gerhardt, 2004). Fathers in this study were sensitive to the mother's feelings about her mother-baby bond and were concerned about affecting it. This led them to consciously consider their own interactions which meant they did not always respond sensitively to their baby's needs. The father's sensitivity to the mother-baby relationship is vital, and has similarities with Goodman (2008), and Mantymaa *et al.*'s (2006) findings.

Similar to findings by Meighan *et al.* (1999) and Webster (2002) the couple's relationship was under strain, particularly when the illness was severe. Fathers were supportive of their partners, and this helped to maintain their relationship. Unlike the literature which shows maternal perinatal mental health is associated with paternal mental health (e.g. Harvey and McGrath, 1988; Lovestone and Kumar, 1993), this study did not find any symptoms indicative of depression, anxiety, or stress as

measured by the DASS-21. Although, for five participants their partner had been discharged and their narratives described symptoms during admission.

Fathers felt anxious when their partner became ill and they had many demands on them. Social support was very important for fathers. Father felt relief that the unit was looking after their partner and they appreciated the expertise. In this way the fathers felt contained by the unit. By responding sensitively to a family's needs healthcare professionals can provide the main functions an attachment figure would; to create a secure base and reduce anxiety (Adshead, 1998).

All fathers experienced uncertainties regarding the illness and treatment. Postnatal mental health can be uncertain and fluctuate rapidly. Fathers wanted to be involved and were aware information could have been shared to reduce uncertainty. However, fathers struggled to establish communication. Their attachment style, personality, and anxiety will all impact on how easily they establish communication with professionals.

There were similarities with literature about carers for people with mental illness. Factors found to affect carer burden include the severity of illness, and length of hospitalisation (Dyck *et al.* 1999). In a systematic review Rowe (2012) found carers 'struggled to cope with the unexpected and unfamiliar demands of a severe mental illness' (p.80.). Barriers to carers providing care were their ability to cope, attitudes of staff, and inadequate communication. Again this shares similarities to fathers experience in the unit; fathers coping skills affect their participation in the unit and

caregiving. Fathers wanted to be more included by professionals and to be given more information.

7.6.1. Clinical implications

Scottish Intercollegiate Guidelines Network (SIGN 2012) and National Institute for Health and Clinical Excellence (NICE, 2007) guidelines recognise the adverse effect postnatal mental illness can have on fathers. They recommend good communication (SIGN, 2012) and promote the inclusion of fathers (NICE, 2007).

In order to reduce father's uncertainty and anxiety, and to enable him to optimally support his partner, it is essential father's develop an understanding of her illness, treatment, and what he can do to facilitate recovery. This can be improved by initially recognising why some fathers struggle to communicate. Then increasing communication between professionals and fathers, and encouraging inclusion in meetings regarding their partner. One-to-one sessions may be helpful to elicit fathers concerns and answer individual questions. Specific information leaflets for fathers detailing expectations and common concerns may facilitate discussion.

The findings show the baby's attachment to the father may be difficult to establish particularly over long admissions when the father visits infrequently. Fathers who acquire the skills to parent sensitively, perhaps through improved communication and exchange of childcare skills between professionals and fathers, may be more likely to achieve a secure attachment relationship irrespective of time together.

Sensitive parenting can be more important than time together in the formation of secure attachments (Brown *et al.* 2007).

7.6.2. Limitations

The narrow generalizability of the results is a limitation. This sample is specific to the perinatal unit and represents those fathers' opinions at one specific time. Findings are only generalizable to fathers experiencing their partner and baby's admission to a perinatal mental health unit.

7.6.3. Further research

Encouraging and facilitating open communication with fathers using written material, face-to-face interaction, and modelling of behaviour could increase his knowledge and skills. This could affect his participation in daily activities in the unit, stress and anxiety, and ability as a caregiver. Research is needed to validate each of these associations.

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Child: Care, Health and Development

Impact Factor: 1.308

Author Guidelines

1. GENERAL

Child: Care, Health and Development is an international, peer-reviewed journal which publishes papers dealing with all aspects of the health and development of children and young people. We aim to attract quantitative and qualitative research papers relevant to people from all disciplines working in child health. We welcome studies which examine the effects of social and environmental factors on health and development as well as those dealing with clinical issues, the organization of services and health policy. We particularly encourage the submission of studies related to those who are disadvantaged by physical, developmental, emotional and social problems. The journal also aims to collate important research findings and to provide a forum for discussion of global child health issues.

4. MANUSCRIPT TYPES ACCEPTED

Original Articles: Articles reporting original scientific data based quantitative or qualitative research are particularly welcomed. Articles should begin with a structured abstract and should ideally be between 2,000 and 3,000 words in length excluding tables and references. In the case of complex qualitative research reports, the editors may be prepared to extend the word limit to 5000 words.

Review Papers: The journal welcomes syntheses of research in the form of systematic reviews. The word limit may be extended, in some circumstances, to 5000 words. Reviews are structured in the same way as original research (see above). The journal will occasionally publish narrative reviews where it is felt that these will be of particular interest to the readers and will be important in encouraging debate.

5. MANUSCRIPT FORMAT AND STRUCTURE

5.2. Structure

The following checklist should be used to check the manuscript before submission. Articles are accepted for publication at the discretion of the Editor. A manuscript reporting original research should ideally be between 2000 and 3000 words. In the case of complex qualitative research reports, or systematic reviews, the editors may in some circumstances be prepared to extend the word limit to 5000 words. The manuscript should consist of the sections listed below.

Title Page: The title page should give both a descriptive title and short title. The title should be concise and give a brief indication of what is in the paper. Authors are required to detail in full: qualifications, current job title, institution and full contact details. Also a word count for the article and keywords should be given on the title page.

Abstract: Structured abstracts, not more than 300 words, including background, methods, results and conclusions are preferred

Optimizing Your Abstract for Search Engines

Many students and researchers looking for information online will use search engines such as Google, Yahoo or similar. By optimizing your article for search engines, you will increase the chance of someone finding it. This in turn will make it more likely to be viewed and/or cited in another work. We have compiled these guidelines to enable you to maximize the web-friendliness of the most public part of your article.

Main Text

Generally, all papers should be divided into the following sections and appear in this order: Abstract (structured abstracts, not more than 300 words, including background, methods, results and conclusions are preferred); Introduction; Methods; Results; Discussion; Acknowledgements (these should be brief and must include references to sources of financial and logistical support); References; Tables; Figures.

Key Messages

From 2007 onwards a key messages box should be provided with each manuscript. This should include up to 5 messages on key points of practice, policy or research. This also applies to articles solicited for themed issues.

5.3. References

References cited in the text should list the authors names followed by the date of their publication, unless there are three or more authors when only the first author's name is quoted followed by et al. References listed at the end of the paper should include **all** authors' names and initials, and should be listed in alphabetical order with the title of the article or book, and the title of the Journal given in full as shown:

Havermans, T. & Eiser, C. (1994) Siblings of a child with cancer. *Child: care, health and development*, **20**, 309-322.

Cart, P. (1984) Observation. In: *The Research Process in Nursing* (ed. D.F.S. Cormack), pp. XX-XX. Wiley-Blackwell, Oxford, UK.

Work that has not been accepted for publication and personal communications should not appear in the reference list, but may be referred to in the text (e.g. 'A. Author, unpubl. observ.' or 'B. Author, pers. comm.'). It is the authors' responsibility to obtain permission from colleagues to include their work as a personal communication. A letter of permission should accompany the manuscript.



The impact of mother and baby's hospitalisation in the perinatal mental health unit on the father's paternal role and relationship with his child

This study is investigating the impact of a mother's and baby's hospitalisation in the perinatal mental health unit on the father's paternal role and relationship with his child. Individual interviews will be used to gather information to answer this question.

I would be very grateful if you could discuss the study with potential participants. Please also give them the "Information Sheet for staff to give to potential participants".

Inclusion and exclusion criteria

- Participants must be the father of an infant in the mother and baby unit or who has previously been in the unit within the last 12 months.
- The father must have visited their partner and child in the unit.
- The father must be over 18 years old.
- The child will be under 12 months old when admitted.
- The father must be fluent in English.
- There are no restrictions on the length of stay.
- No restrictions on the number of children the father has.
- There are no restrictions on the health board the family has been referred from.
- They must be Scottish residents.
- They must not be experiencing a high level of distress.

As the study progresses I may wish to follow certain emerging themes and require participants that are going to further enhance this area of the study, for example I may want to interview someone who has to travel a long way to visit their partner, therefore all potential participants may not be required.

**If a father tells you they wish to participate in the study please collect their contact details, and contact me on 01506 523 615, or by email
Then I will arrange to meet them for an interview in your department.**

Should you have any questions please do not hesitate to contact me.

Yours Faithfully,

Jen Marrs

Trainee Clinical Psychologist
Psychology Department
St John's Hospital at Howden
Howden Road West
Livingston EH54 6PP



What is the impact on the father when his partner and baby are admitted to the mother and baby unit?

You are being invited to take part in a research study. Before you decide whether or not to take part, it is important for you to understand why the research is being done and what it will involve. Please take time to read the following information carefully. Talk to others about the study if you wish. Contact us if there is anything that is not clear or if you would like more information. Take time to decide whether or not you wish to take part.

What is the purpose of the study?

This study is investigating the impact on fathers when their partner and baby are admitted to the perinatal mental health unit. We are particularly interested in the impact that your partner and baby's hospitalisation has on your role as a father and your relationship with your baby. This is a relatively unexplored subject area. Historically fathers have been in the background when it comes to perinatal research but their importance is starting to be recognised.

Why have I been asked to take part?

You have been asked to take part as your partner is currently in the mother and baby unit.

Do I have to take part?

No, it is up to you to decide whether or not to take part. If you do decide to take part you will be given this information sheet to keep and be asked to sign a consent form. If you decide to take part you are still free to withdraw at any time and without giving a reason. Deciding not to take part or withdrawing from the study will not affect you or your family.

What will happen if I take part?

Participation in the study would involve a one-to-one interview which would last approximately 60 minutes. In the interview you would be asked questions about your experience of your partner and baby being in the perinatal mother and baby unit. You would also be required to complete a short demographic form and a Depression Anxiety and Stress Scale (DASS) which would take around 10 minutes. Participants have the option to be contacted again to discuss a transcript of their interview. Not all participants will need to be contacted.

What are the possible benefits of taking part?

Although you may not personally experience any benefit from participation your input could help to inform future services for families such as yours.

What are the possible disadvantages and risks of taking part?

It is not thought that there are any disadvantages; however, it is possible that you may become upset discussing this topic or afterwards. The researcher is used to talking to people about sensitive topics and would help you to feel at ease. You would also be supplied with some helpful telephone numbers should you want to discuss your concerns further. You are free to withdraw from the study at any time.

Although it is unlikely to happen I should inform you that if you were to tell the researcher about anything which poses a child protection risk to your child then I would be obliged to pass that information on to the appropriate services.

When you meet with the researcher it is likely to take between 60 minutes to 90 minutes to complete the forms and the interview. You will only be required to meet with the researcher once unless you opt in to be contacted about your transcript. Discussing a transcript will take one session which may last up to 60 minutes.

What happens when the study is finished?

The study will be complete in August 2012. You can request a summary of the results then. All data will be stored anonymously in secure cabinets for 5 years before it is destroyed.

Will my taking part in the study be kept confidential?

All the information we collect during the course of the research will be kept confidential and there are strict laws which safeguard your privacy at every stage. Your name will be removed from the data so that you cannot be recognised from it. The only information which could not be kept confidential would be when something was discussed which raised child protection concerns.

What will happen to the results of the study?

The study will be written up as thesis and a smaller report which the researcher aims to publish. You will not be identifiable in the reports.

Who is organising the research and why?

This study has been organised Jen Marrs as part of her D.Clin.Psychol. qualification.

Who has reviewed the study?

The study proposal has been reviewed by The University of Edinburgh Clinical Psychology training programme. A favourable ethical opinion has been obtained from South East Scotland REC. NHS management approval has also been obtained,

If you have any further questions about the study please contact Jen Marrs on: (01506 523 615) or email: Jen.Marrs@nhslothian.scot.nhs.uk

If you would like to discuss this study with the research supervisor please contact Dr. Jill Cossar on email: jill.cossar@ed.ac.uk

What do I do now?

Please let a member of staff know you want to participate in the study. Alternatively you can contact me on 01506 523 615, or by email

If you wish to make a complaint about the study please contact NHS Lothian:

NHS Lothian Complaints Team
2nd Floor
Waverley Gate
2-4 Waterloo Place
Edinburgh
EH1 3EG
Tel: 0131 465 5708

Thank you for taking the time reading this information sheet.



What is the impact on the father when his partner and baby are admitted to the mother and baby unit?

You have been sent this letter because your partner was previously an inpatient at the mother and baby unit in Livingston and you are being invited to take part in a research study. Before you decide whether or not to take part, it is important for you to understand why the research is being done and what it will involve. Please take time to read the following information carefully. Talk to others about the study if you wish. Contact us if there is anything that is not clear or if you would like more information. Take time to decide whether or not you wish to take part.

What is the purpose of the study?

This study is investigating the impact on fathers when their partner and baby are admitted to the perinatal mental health unit. We are particularly interested in the impact that your partner and baby's hospitalisation had on your role as a father and your relationship with your baby. This is a relatively unexplored subject area. Historically fathers have been in the background when it comes to perinatal research but their importance is starting to be recognised.

Why have I been asked to take part?

You have been asked to take part as your partner was in the mother and baby unit recently.

Do I have to take part?

No, it is up to you to decide whether or not to take part. If you do decide to take part you will be given this information sheet to keep and be asked to sign a consent form. If you decide to take part you are still free to withdraw at any time and without giving a reason. Deciding not to take part or withdrawing from the study will not affect you or your family.

What will happen if I take part?

Participation in the study would involve a one-to-one interview which would last approximately 60 minutes. In the interview you would be asked questions about your experience of your partner and baby being in the perinatal mother and baby unit, and your experience more recently. You would also be required to complete a short demographic form and a Depression Anxiety and Stress Scale (DASS) which would take around 10 minutes. Participants have the option to be contacted again to discuss a transcript of their interview. Not all participants will need to be contacted.

What are the possible benefits of taking part?

Although you may not personally experience any benefit from participation your input could help to inform future services for families such as yours.

What are the possible disadvantages and risks of taking part?

It is not thought that there are any disadvantages; however, it is possible that you may become upset discussing this topic or afterwards. The researcher is used to talking to people about sensitive topics and would help you to feel at ease. You would also be supplied with some helpful telephone numbers should you want to discuss your concerns further. You are free to withdraw from the study at any time.

Although it is unlikely to happen I should inform you that if you were to tell the researcher about anything which poses a child protection risk to your child then I would be obliged to pass that information on to the appropriate services.

When you meet with the researcher it is likely to take between 60 minutes to 90 minutes to complete the forms and the interview. You will only be required to meet with the researcher once unless you opt in to be contacted about your transcript. Discussing a transcript will take one session which may last up to 60 minutes.

What happens when the study is finished?

The study will be complete in August 2012. You can request a summary of the results then. All data will be stored anonymously in secure cabinets for 5 years before it is destroyed.

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If you would like to discuss this study with the research supervisor please contact Dr. Jill Cossar on email: jill.cossar@ed.ac.uk

What do I do now?

If you want to participate please complete and return the enclosed slip in the self-addressed envelope. Alternatively you can contact **Anna Wroblewska** on **01506 524176**

If you wish to make a complaint about the study please contact NHS Lothian:
NHS Lothian Complaints Team
2nd Floor
Waverley Gate
2-4 Waterloo Place
Edinburgh
EH1 3EG
Tel: 0131 465 5708

Thank you for taking the time reading this information sheet.



What is the impact on the father when his partner and baby are admitted to the mother and baby unit?

I wish to participate in the study. Please contact me to arrange an interview.

Name.....

Address.....

.....

.....

.....

.....

Telephone Number

DASS₂₁

Name:

Date:

Please read each statement and circle a number 0, 1, 2 or 3 which indicates how much the statement applied to you *over the past week*. There are no right or wrong answers. Do not spend too much time on any statement.

The rating scale is as follows:

- 0 Did not apply to me at all
- 1 Applied to me to some degree, or some of the time
- 2 Applied to me to a considerable degree, or a good part of time
- 3 Applied to me very much, or most of the time

1	I found it hard to wind down	0	1	2	3
2	I was aware of dryness of my mouth	0	1	2	3
3	I couldn't seem to experience any positive feeling at all	0	1	2	3
4	I experienced breathing difficulty (eg, excessively rapid breathing, breathlessness in the absence of physical exertion)	0	1	2	3
5	I found it difficult to work up the initiative to do things	0	1	2	3
6	I tended to over-react to situations	0	1	2	3
7	I experienced trembling (eg, in the hands)	0	1	2	3
8	I felt that I was using a lot of nervous energy	0	1	2	3
9	I was worried about situations in which I might panic and make a fool of myself	0	1	2	3
10	I felt that I had nothing to look forward to	0	1	2	3
11	I found myself getting agitated	0	1	2	3
12	I found it difficult to relax	0	1	2	3
13	I felt down-hearted and blue	0	1	2	3
14	I was intolerant of anything that kept me from getting on with what I was doing	0	1	2	3
15	I felt I was close to panic	0	1	2	3
16	I was unable to become enthusiastic about anything	0	1	2	3
17	I felt I wasn't worth much as a person	0	1	2	3
18	I felt that I was rather touchy	0	1	2	3
19	I was aware of the action of my heart in the absence of physical exertion (eg, sense of heart rate increase, heart missing a beat)	0	1	2	3
20	I felt scared without any good reason	0	1	2	3
21	I felt that life was meaningless	0	1	2	3

DASS

Scoring Template

Best printed on an overhead transparency sheet

S
A
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A

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S
A
S
A

D
S
S
D
S

A
D
D
S
A

A
D

Apply template to sheet and sum scores for each scale.
For short (21-item) version, multiply sum by 2.

DASS Severity Ratings

The DASS is a **quantitative** measure of distress along the axes of depression, anxiety (symptoms of psychological arousal) and stress (the more cognitive, subjective symptoms of anxiety). It is **not** a categorical measure of clinical diagnoses.

Emotional syndromes like depression and anxiety are intrinsically dimensional – they vary along a continuum of severity (independent of the specific diagnosis). Hence the selection of a single cut-off for a specific diagnosis can be correctly recognised as experiencing considerable symptoms and as being at high risk of further problems.

However for clinical purposes it can be helpful to have 'labels' to characterise degree of severity relative to the population. Thus the following cut-off scores have been developed for defining mild/moderate/severe/extremely severe scores for each DASS scale.

Note: the severity labels are used to describe the full range of scores in the population, so 'mild' for example means that the person is above the population mean but probably still way below the typical severity of someone seeking help (ie it does not mean a mild level of disorder).

The individual DASS scores do not define appropriate interventions. They should be used in conjunction with all clinical information available to you in determining appropriate treatment for any individual.

With the above information in mind, we offer the following guidelines based on full (42 item) scores (if using the DASS 21 item version, multiply the score obtained by 2).

DASS Severity Ratings

(if using the DASS 21 item version, multiply the score obtained by 2)

	Depression	Anxiety	Stress
Normal	0-9	0-7	0-14
Mild	10-13	8-9	15-18
Moderate	14-20	10-14	19-25
Severe	21-27	15-19	26-33
Extremely Severe	28+	20+	34

Source: Psychology Department, UNSW - www.psy.unsw.edu.au/dass



The impact of mother and baby's hospitalisation in the perinatal mental health unit on the father's paternal role and relationship with his child

Age? _____

How many children do you have? _____

Marital status (please tick):

- In a relationship and living separately ☐
 In a relationship and co-habiting ☐
 Married ☐
 Separated ☐

Ethnicity:

(Choose one section from A to F, then **tick** the appropriate box to indicate your cultural background)

A: White ☐ Scottish ☐ Irish ☐ Other British
☐ Any other White background

B: Mixed ☐ Any mixed background

C: Asian; Asian Scottish; Asian British

- ☐ Pakistani ☐ Indian ☐ Chinese
☐ Bangladeshi ☐ Any other Asian Background

D: Black; Black Scottish; Black British

- ☐ Caribbean ☐ African
☐ Any other Black background

E: Other ethnic background

- ☐ Any other background

F: Prefer not to answer ☐

Occupational Status:

- ☐ Unemployed ☐ Employed part-time ☐ Employed full-time
☐ Student ☐ Self employed

Occupation: _____



What is the impact on the father when his partner and baby are admitted to the mother and baby unit?

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What is the purpose of the study?

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Why have I been asked to take part?

You have been asked to take part as your partner is currently in the mother and baby unit.

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What will happen if I take part?

Participation in the study would involve a one-to-one interview which would last approximately 60 minutes. In the interview you would be asked questions about your experience of your partner and baby being in the perinatal mother and baby unit. You would also be required to complete a short demographic form and a Depression Anxiety and Stress Scale (DASS) which would take around 10 minutes. Participants have the option to be contacted again to discuss a transcript of their interview. Not all participants will need to be contacted.

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Although it is unlikely to happen I should inform you that if you were to tell the researcher about anything which poses a child protection risk to your child then I would be obliged to pass that information on to the appropriate services.

When you meet with the researcher it is likely to take between 60 minutes to 90 minutes to complete the forms and the interview. You will only be required to meet with the researcher once unless you opt in to be contacted about your transcript. Discussing a transcript will take one session which may last up to 60 minutes.

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If you would like to discuss this study with the research supervisor please contact Dr. Jill Cossar on email: jill.cossar@ed.ac.uk

What do I do now?

Please let a member of staff know you want to participate in the study. Alternatively you can contact me on 01506 523 615, or by email

If you wish to make a complaint about the study please contact NHS Lothian:

NHS Lothian Complaints Team
2nd Floor
Waverley Gate
2-4 Waterloo Place
Edinburgh
EH1 3EG
Tel: 0131 465 5708

Thank you for taking the time reading this information sheet.



What is the impact on the father when his partner and child are admitted to the mother and baby unit?

Tick the box

- I have read the participant information sheet ☐
- I have had the opportunity to ask questions ☐
- I consent to participate in the study ☐
- I consent to the interview being audio recorded ☐
- I consent to the recordings being used for research purposes ☐
- I understand my data will be anonymous & stored in secure filing cabinets ☐
- I understand that I am free to withdraw from the study at any time without having to provide a reason. ☐
- I agree to be contacted in the future to discuss the interview transcript (Contact details) ☐

Participants name _____ Signature _____

Date _____

Name of Chief Investigator _____ Jen Marrs _____ Signature _____

Date _____



The impact of mother and baby's hospitalisation in the perinatal mental health unit on the father's paternal role and relationship with his child

Helplines and Crisis Support

If you find you are feeling upset after you have left the interview and require someone to talk to about your feelings you may contact the following people:

Your own General Practitioner (GP)

Samaritans 08457 909090

Breathing Space 0800 838 587
(weekday: 6pm- 2am;
weekend: Fri 6pm – Mon 6am)

Interviewer's words are in **bold**.

.....

(06.26)What was that first visit like, when you arrived here?

Erm very mixed emotions because it was the first time I had seen my wife afterwards so you know obviously I was really worried, wanted to know if she was ok, but I didn't really know that until I had seen her. I realised that she had obviously been hiding her illness for so long, because it was even obvious to me when I first seen her that she wasn't the woman I left 6 weeks ago to go to work.

So do you think it had been quite a decline?

Yer a decline. And of course when you realise that, when she was diagnosed with the illness, and long before that, with hindsight looking in you can pick out various points in time over the last couple of years probably when she had symptoms of depression but you couldn't really put the pieces together until.

So it's not been so severe in the past?

Not been so severe in the past although, certainly afterwards we definitely identified something after our second child was born. I believed I saw had and discussed it with my wife at the time, but it was always denied, or she would deny it. And of course the next day everything would be normal. Everybody as a couple always has fights but you come to some kind of agreement or resolve it in some way and carry on. We did that, we did that for the most part. But after our second child was born I we couldn't, we weren't able to resolve any differences that we had in the normal manner. And of course I was thinking maybe it's me, have I changed in any way, have I become less rational or erm so I was asking my friends and saying do I seem ok to you guys? "you seem ok" so I said well I think there is something we are not quite getting here. But she did a couple of times, the only thing that made me notice was that she was noticeably having less self-esteem. Because quite often any argument we would have would end up with her saying I don't mean this and I'm this.. just small things, all things that I would say don't worry about that. That's not true. It would be forgotten about. A week later everything would be ok. Except what was obvious after our second child was born, that's when we noticed. The doctors have since then believed that yes it's before that, certainly since the second child was born, there's some kind of underlying condition.

Were similar things happening before you went away for that 6 weeks?

Not as much because we haven't been fighting we had no bad feelings between us. I only noticed that again (partner) was being really tired. But of course it's hard to separate that and the fact we have got 3 children. And that's only my second time going away after baby was born.

Right. (10.00)

Baby's only a couple of months old. And of course she was feeding her and we had talked about, ok, maybe we can get her onto bottles sooner than we did with the other 2. Just because it's going to be harder work for (partner) doing it on her own. And we discussed the normal things. We thought it'd be a good idea we try it a couple of times without giving any seriousness to the two of us. For the most part (partner) didn't really want to bottle feed her. So just try and relieve the tiredness, one thing I thought is we can try and relieve your tiredness is one factor I thought. We can try and relieve your tiredness because she was really tired. Of course this excessive tiredness is obviously part of her illness getting worse and worse. Her depression. And also the fact that she was trying to prove to herself she wasn't struggling coping with kids. She was doing more than she would usually do. The dr was saying that's just a reacting thing for a mother, "I'm ok, I am well, I can do this, and I can do this" "I will take my children here and there" without asking for help. Just to say that she was obviously feeling worried herself about being a good mum. And of course as we know now that's ...instead of making herself feel better she was just making herself feel more tired and feel the illness.

So it sounds like it was quite a surprise to you.?

Quite a surprise yer for me it was a surprise just to see how ill she was. Without realising it. Even though all those factors were coming back to me and talking to the nursing staff and they were explaining to me she obviously was, before I came to visit her. I built a picture in my mind of what she was like. Until you see somebody that ill you don't really ... what you are expecting. She was totally not good, emotionally and her personality was ... she wasn't the same happy wife I had left.

Was those phone conversations with the staff helpful to prepare you?

Yes I think so yer. I mean I spoke to obviously the doctors and a couple of nurses in (home hospital) where she went originally. And also, more so from, I don't really know, they don't know (partner) as much, she was just a patient that was submitted to the hospital but there was also the health visitor who's been in charge of checking up on the children through all the children. So obviously she knows the family so she was obviously involved in the case very early on. So I spoke to her on the phone a couple of times. She gave a better insight into (partner)'s personality. And she knows (partner) any way so she was obviously very surprised as were her friends. I always thought in this case that (partner)'s close friends were a good gauge of how ill she was or how she managed to hide all this. Close friends, I am sure (partner) must rather confide in them that she would me in some cases because girls are like that I always find. And er certainly I normally believe that (partner) is inclined to confide in them any problems that she has. And she hadn't done that, well anyway a couple of close friends they were just as surprised as me, if not more so. They were almost more upset than me because they didn't see it. Again this is part of.. they are all mothers in the same position with 2 or 3 young children. And they were quite upset that they hadn't noticed her change in mood or anything. But she had been hiding it that's why.

Have friends and family been supportive to you and (partner) while you have been in here? 13.56

Yer. Especially. Family absolutely. I've got, as far as close family is concerned obviously (partner)'s parents are excellent. They obviously stepped in straight away to look after the kids. And I said that's not a worry at all because they are so used to having them so even though they haven't had them for weeks at a time they have had them weekends, long weekends, just random nights, so that was no problem. Also her sister, she lives in (...) so it's not obviously a convenient place to help but she is always able to help at any time for visiting. We would come down here. She would look after the kids if necessary. My sister she's just started to become more and more involved, which as an aunty she wouldn't necessarily visit every day but she's started coming round every day after work, to my home.

Right ok. (15.00)

And er. So she's obviously helped. And any subsequent visits here she has come with me, which is a lot easier with two young children. To look after and entertain as well when I've a sick wife. Yes, so family and friend support has been very good. And friends on top of that they help all the time, they just call at random or or or pick them up after school, one of the mothers (partner)'s friends, after school take them for tea, take them home again. So you get that. You don't have to ask for help, people are volunteering extra support.

You have not really had to ask?

So I've not really asked and what tends to happen the times I have had to ask "can you go to this at such and such a time" "No problem" you know what I mean. I've not just got 2 people to call on I've actually got a large network of friends.

...

www.nhsllothian.scot.nhs.uk

Date
Our Ref
Enquiries to Joyce Clearie
Extension 35674
Direct Line 0131 465 5674
Email

11 November 2011

Miss Jennifer Marrs
Trainee Clinical Psychologist
NHS Lothian
School of Health in Social Science
The University of Edinburgh, Teviot Place
Edinburgh
EH8 9AG

Dear Miss Marrs

Study title: The impact of a mother's and baby's hospitalisation in the perinatal mental health unit on the father's paternal role and relationship with his child.

REC reference: 11/SS/0064

Thank you for your letter of 31 October 2011, responding to the Committee's request for further information on the above research and submitting revised documentation.

The further information was considered by the Chair on behalf of SESREC 3.

Confirmation of ethical opinion

On behalf of the Committee, I am pleased to confirm a favourable ethical opinion for the above research on the basis described in the application form, protocol and supporting documentation as revised, subject to the conditions specified below.

Ethical review of research sites

[Omit this sub-section if no NHS sites will be taking part in the study, e.g. Phase 1 trials in healthy volunteers]

NHS sites

The favourable opinion applies to all NHS sites taking part in the study, subject to management permission being obtained from the NHS/HSC R&D office prior to the start of the study (see "Conditions of the favourable opinion" below).

Non-NHS sites

Conditions of the favourable opinion

The favourable opinion is subject to the following conditions being met prior to the start of the study.

Management permission or approval must be obtained from each host organisation prior to the start of the study at the site concerned.

Management permission ("R&D approval") should be sought from all NHS organisations involved in the study in accordance with NHS research governance arrangements.

Guidance on applying for NHS permission for research is available in the Integrated Research Application System or at <http://www.rdforum.nhs.uk>.

Where a NHS organisation's role in the study is limited to identifying and referring potential participants to research sites ("participant identification centre"), guidance should be sought from the R&D office on the information it requires to give permission for this activity.

For non-NHS sites, site management permission should be obtained in accordance with the procedures of the relevant host organisation.

Sponsors are not required to notify the Committee of approvals from host organisations

It is the responsibility of the sponsor to ensure that all the conditions are complied with before the start of the study or its initiation at a particular site (as applicable).

Approved documents

The final list of documents reviewed and approved by the Committee is as follows:

Document	Version	Date
GP/Consultant Information Sheets	1 Information Sheet for Staff	03 October 2011
Interview Schedules/Topic Guides	1	03 October 2011
Investigator CV		30 September 2011

Investigator CV	Cossar Ac Supervisor	12 September 2011
Letter of invitation to participant	1 Letter to potential participants no longer in the unit	03 October 2011
Other: Caldicott Guardian Authorisation	1	22 September 2011
Other: Cover letter for ?s for perinatal unit	1	03 October 2011
Other: ?s for perinatal unit	1	03 October 2011
Other: Demographic form	1	03 October 2011
Other: Mental Health Contact Numbers	1	03 October 2011
Other: Info posted to potential participants	2	31 October 2011
Participant Consent Form: PCF	3	31 October 2011
Participant Information Sheet: PIS and (CF)	3	31 October 2011
Participant Information Sheet: Info Sheet for Staff to give to participants	2	31 October 2011
Protocol	1	03 October 2011
Questionnaire: DASS-21 mark scheme and severity		
REC application	1	03 October 2011
Referees or other scientific critique report	1	13 July 2011
Response to Request for Further Information		31 October 2011

Statement of compliance

The Committee is constituted in accordance with the Governance Arrangements for Research Ethics Committees (July 2001) and complies fully with the Standard Operating Procedures for Research Ethics Committees in the UK.

After ethical review

Reporting requirements

The attached document “*After ethical review – guidance for researchers*” gives detailed guidance on reporting requirements for studies with a favourable opinion, including:

- Notifying substantial amendments
- Adding new sites and investigators
- Notification of serious breaches of the protocol
- Progress and safety reports
- Notifying the end of the study

The NRES website also provides guidance on these topics, which is updated in the light of changes in reporting requirements or procedures.

Feedback

You are invited to give your view of the service that you have received from the National Research Ethics Service and the application procedure. If you wish to make your views known please use the feedback form available on the website.

Further information is available at National Research Ethics Service website > After Review

11/SS/0064

Please quote this number on all correspondence

With the Committee's best wishes for the success of this project

Yours sincerely

Dr Christine West
Chair

Email:

Enclosures:

"After ethical review – guidance for researchers" [\[SL-AR2\]](#)

Copy to:

Ms Marise Bucukoglu

Ms Karen Maitland, The Queen's Medical Research Institute

University Hospitals Division

Queen's Medical Research Institute
47 Little France Crescent, Edinburgh, EH16 4TJ

CPP/SS/approval

16 November 2011

Dr Anna Wroblewska
Mental Health, Mother and Baby Unit
St John's Hospital
Livingston
EH54 6PP

Dear Dr Wroblewska,



Research & Development
Room E1.12
Tel: 0131 242 3330
Fax: 0131 242 3343

Email:

R&DOffice@luht.scot.nhs.uk

Director:

Professor David E Newby

Lothian R&D Project No: **2011/SJ/PSY/03**

Title of Research: The impact of a mother's and baby's hospitalisation in the perinatal mental health unit on the father's paternal role and relationship with his child

REC No: 11/SS/0064

CTA No: N/A

Eudract: N/A

PIS: Version 1 dated 03 October 2011

Consent: Version 1 dated 03 October 2011

Protocol No: version 1 dated 13 April 2011

I am pleased to inform you that this study has been approved for NHS Lothian and you may proceed with your research, subject to the conditions below. This letter provides Site Specific approval for NHS Lothian.

Please note that the NHS Lothian R&D Office must be informed if there are any changes to the study such as amendments to the protocol, recruitment, funding, personnel or resource input required of NHS Lothian. This includes any changes made subsequent to management approval and prior to favourable opinion from the REC.

Substantial amendments to the protocol will require approval from the ethics committee which approved your study and the MHRA where applicable.

Please inform this office when recruitment has closed and when the study has been completed.

I wish you every success with your study.

Yours sincerely

Dr Christine P Phillips
Deputy R&D Director

Cc Stewart Morgan, NRS

Coordinator/Administrator: JMcG/ LR
Direct Line: 0141 211 8548
E-mail:
Website: www.nhsggc.org.uk/r&d

18th April 2012

Dr Roch Cantwell
Consultant in Perinatal Psychiatry
Department of Psychiatry Health Service
Southern General Hospital
1345 Govan Road
Glasgow
G51 4TF

NHS GG&C Board Approval

Dear Dr Cantwell

Study Title: The impact of a mother's and baby's hospitalisation in the perinatal mental health unit on the father's paternal role and relationship with his

Chief Investigator: Miss Jennifer Marrs

GG&C HB site: SGH

Sponsor: NHS Lothian / University of Edinburgh

GG&C R&D Reference: GN11FP383

REC Ref: 11/SS/0064

Protocol no: Not Versioned dated 13/04/11

I am pleased to confirm that Greater Glasgow & Clyde Health Board is now able to grant **Approval** for the above study.

Conditions of Approval

1. **For Clinical Trials** as defined by the Medicines for Human Use Clinical Trial Regulations, 2004
 - a. During the life span of the study GGHB requires the following information related solely to this site
 - i. Notification of any potential serious breaches.
 - ii. Notification of any regulatory inspections.

It is your responsibility to ensure that all staff involved in the study at this site have the appropriate GCP training according to the GGHB GCP policy (www.nhsggc.org.uk/content/default.asp?page=s1411), evidence of such training to be filed in the site file.

2. **For all studies** the following information is required during their lifespan.
 - a. Recruitment Numbers on a quarterly basis
 - b. Any change of staff named on the original SSI form
 - c. Any amendments – Substantial or Non Substantial
 - d. Notification of Trial/study end including final recruitment figures

e. Final Report & Copies of Publications/Abstracts

Please add this approval to your study file as this letter may be subject to audit and monitoring.

Your personal information will be held on a secure national web-based NHS database.

I wish you every success with this research study

Yours sincerely

**Joanne McGarry
Research Co-ordinator**

**Cc: Miss Jennifer Marrs, Chief Investigator, University of Edinburgh.
NRSPCC, NHS Grampian.**

Ms Jen Marrs
Psychology Department
St John's Hospital
LIVINGSTON
EH54 6PP

Date 22nd September 2011
Your Ref
Our Ref JMS/fb/11178
Enquiries to Jim Sherval
Extension
Direct Line 0131 465 5461
Email

Dear Ms Marrs

The impact of the mother's and baby's hospitalisation in the perinatal mental health unit on the father's paternal role and relationship with his child.

Thank you for the information supplied

Request received from	Ms Jen Marrs, Psychology Department, St John's Hospital
Summary of proposal	The impact of the mother's and baby's hospitalisation in the perinatal mental health unit on the father's paternal role and relationship with his child
Patient identifiable information requested	Forename, Surname, Address, Postcode
Approved	YES
Advice	

Yours sincerely

Dr Alison McCallum
Director of Public Health & Health Policy

Example Memos Handwritten memos were recorded throughout the research project. A selection of example memos will be presented here.

26.02.12 Taking each day as it comes The father mentioned ‘winging it’, ‘taking each day as it comes’. What does this mean? He seemed to have little direction in what to do to manage day-to-day and support his partner. Is it a way of coping practically, taking the challenges as they arise. Could it be a way of coping emotionally? A way of not worrying about the implications of the illness in the future? Include in interview questioning.

26.02.12 The father baby bond. Although I have only had one interview I had thought the fathers would have had more to say about their baby and their relationship. However, there was not much quality discussion on this. I will persevere questioning around the baby as it may be something specific to this participant. I am wondering if the outcome of the study is going to be more about the dynamics of the whole family. Also the difficulty of the whole experience is striking. There appear to be complex mother-father-child relationships with the inclusion of staff. Is the staffs role like a grandparent?-possibly not, maybe they are a ‘professional outsider’. Consider the dynamics between family members, and staff.

15.03.12 Recruiting participants The couple relationship
Following an initial flurry of participants wanting to take part I haven’t had any letters recently. I asked a participant why he thought there wasn’t many participants coming forwards who currently had their partner in the unit. He said that if I had asked him when he was in the unit he wouldn’t have come forwards. He wouldn’t have wanted his partner knowing he was coming to the interview when she was in there waiting for him. This is helpful to know. But it also highlights an aspect of the couple relationship – father’s time is precious and there is an expectation to be there to support the partner.

11.04.12 Other children to care for Retaining normality
This participant described a very strong and clear role to care for his other children. His combination of demands (a very large distance from home and 2 older children), his security in his wife and baby’s care being held in the unit, and his beliefs about his children needing to bond makes his role different to the other fathers. He tries to keep their routines and retain normality to reduce distress and facilitate their mothers return home. The combination of demands on fathers can affect the roles, explore?

12.04.12 Interviewing when partner in unit Although I thought it would be more important to get participants who are in the middle of the unit experience the ones I have had so far have not had the reflective quality of the participants whose partner has been discharged from the unit. Perhaps it is difficult to understand and process the experience when you are in the middle of it?

11.05.12 Reaching saturation? I am wondering if I am reaching saturation. The last few interviews haven’t resulted in any novel categories or ideas. Although they have helped to understand some aspects of some categories. The most recent interview hasn’t sparked any new questions, even during the transcription however I still need to code it.

The screenshot displays the NVivo software interface with the following components:

- Top Menu Bar:** File, Home, Create, External Data, Analyze, Docked, Undock All, Close All, Window, Workspace.
- Left Panel (Workspace):**
 - Navigation View:** Find, Quick Coding, Detail View.
 - Find:** Dock All, Undock All, Close All.
 - Quick Coding:** Detail View, View.
 - Workspace:** Nodes, Relationships, Node Matrices.
- Central Panel:**
 - Nodes:** A list of nodes with checkboxes and colored circles. Nodes include: Bonding with baby, Father needing to bond, Feeling left out, Feeling figure, Importance of mother baby bond, Making time for siblings to bond, Missing baby, Taking cue from mother, Too young to do much, Feeling Contained, Feeling disempowered, Feeling Overwhelmed, getting better, Interesting Quotes, Keeping Family together, Managing, experiencing uncertainty, communication with partner, communication with staff, Taking each day as it comes, Uncertainty regarding treatment, Understanding illness, Unsure in role.
 - Search In:** Nodes.
 - Look for:** Participant 2 transcript.
 - Click to edit:** A link to edit the transcript.
- Right Panel:**
 - Transcript:** A text window showing a transcript of Participant 2. The text includes: "things. But I felt a bit awkward at times when I went down because...at times I almost felt 'are the staff watching me?' albeit that it is quite informal with plain clothes on etc but ...erm ..that's how I felt at times 'are they watching me? Are they watching family?' 'It sounds like it wasn't just your partner that felt 'are they watching me?' (31.00) You can read into things in life. You know you are a bit ...all of a sudden you are not ...you are in a different environment and you're anxious anyway because your wife and your new born baby, that you're trying to see and bond with yourself, and you're not with them as much. You know that's general anxiety that I think any father who's partner and new born are in a mother and baby unit would go through anxiety anyway. What were your interactions? Erm I always made a point when I was there to ...if she was due a feed, a bottle feed, because (partner) went from breast feeding to bottle feeding when she was there. Went in to feed (baby), change her nappy, erm you know as well as giving her wee kisses and cuddling her. Trying to get her used to my voice. Yer. Albeit there is not a great deal you can do with a new born baby. You can't in some ways because a lot of the time they're sleeping, or feeding. But yer, trying what I could. Just natural things. Yer so it sounds like you got in there Oh yer And tried to do a bit of feeding Yer".
 - Coding Density:** A chart showing the density of coding across the transcript. The chart has a horizontal axis labeled "Coding Density" and a vertical axis with labels: communication with staff, Feeling watched, Anxiety re. illness, Too young to do much, Feeling left out, Father needing to bond, Bonding with baby.
- Bottom Panel:**
 - Navigation View:** Sources, Nodes, Classifications, Collections, Queries, Reports, Models, Folders.
 - Workspace:** Nodes, Relationships, Node Matrices.
- System Tray:** Shows the date and time as 17:20 02/07/2012.

